The Public Health Nurse

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The PUBLIC HEALTH NURSE

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CONVERSATIONS

Everyone who reads the daily papers or who possesses a radio—and both are firmly fixed American habits—knows the "direct contact" diplomatic conversations that have been taking place so hopefully for the first time in history between the heads of two great nations.

Tucked away more modestly than these records have been the notes of Miss Ishbel MacDonald's more or less public conversations in connection with the brief investigations she has been able to make of social conditions in this country, especially those concerned with children. In Washington, Miss MacDonald visited the Children's Bureau and the Department of Labor, and in New York came directly to the old friend of her father and herself, Miss Lillian Wald. Miss Wald's warm and generous hospitality has welcomed many notable guests to the Henry Street Settlement over a long period of time, but Miss MacDonald's close association with her father's mission and her interest in the nursing service makes this special visit a significant link with nurses. Miss MacDonald has had some years of social service experience, is a member of the London County Council, and speaks from a background of knowledge when she gives her opinion on a subject very familiar to our own processes of thought. We quote from her speech at the luncheon given for her at the headquarters of the Henry Street Nursing Service:

> Women have more power than they had in the past to build up through political action and trade union work, as well as social service, a better world than they found. We can now directly help bring about improvements through political action.
>
> There are many who believe that social service should be carried on by private individuals. There are others of us in Great Britain who believe that this is an uncertain way of carrying out improvements. I believe that we should not rely on voluntary service but on governments and municipalities to take over the responsibility of health clinics, good housing and many other things which are often run by small committees. What is the use of spending a great deal of private time and money if we are not helped by publicly elected bodies such as our town council, municipalities and the government of the country itself?

We hope Miss MacDonald will some day return for more extended conversations with her sisters in social service in this country and help, through these occasions of friendly understanding, towards that millenium always at the back of our minds of universal peace and social welfare. A. M. C.

REPORT OF THE ANNUAL MEETING AMERICAN PUBLIC HEALTH ASSOCIATION

Bigger and better would be the expression of opinion of those who attended the Fifty-eighth Annual Meeting of the American Public Health Association in Minneapolis from September 30th to October 5th. From the viewpoint of the public health nurse, at least, the meeting at the same time of Related Societies contributed much to the occasion.

The sessions of the American Child Health Association and the two-day program of the Northwest Conference for Child Health and Parent Education

were particularly stimulating and gave new food for thought. How to do better what is now being done, was one of the most suggestive and encouraging objectives of these programs. At the session of the Child Health Association on Morbidity and Mortality of Mothers and Newborn Infants, it was suggested that the supervision of physicians participating in maternity work would be of value!

One of the highlights of the week was the opportunity on Monday to attend the dedication of the Public Health Pavilion and the Out-Patient Service of the University Hospital. The exercises began with a guided visit of inspection of these attractive and efficient-appearing buildings. The program was held out of doors and included inspiring addresses by Dr. C.-E. A. Winslow and Dr. Haven Emerson.

A delightful complimentary luncheon was given at the close of the exercises at the Minnesota Union. Dr. Richard O. Beard, who someone described as the youngest oldest man in Minneapolis, presided at this gathering. His hospitality and kindness on this occasion and throughout the week appeared untiring and limitless.

The ballroom at the Nicollet Hotel was filled to capacity at the Thursday night banquet to hear Dr. George E. Vincent, president of the Rockefeller Foundation, speak. His subject, "Through the Eyes of the Doctor," was delivered in Dr. Vincent's usual dynamic and sparkling fashion. He placed great emphasis upon the need of "Team Play" between the public health group and the doctors.

One could not do justice to these meetings without a word about the exhibits. The Minneapolis Auditorium, where most of the meetings were held, lent itself particularly well to this display. One could have spent the entire week studying the exhibits with profit. They were divided into five groups—(1) Sanitation on community hygiene; (2) The early discovery and prevention of disease; (3) The means to child development; (4) The health use of recreational activities; and (5) The reëducation of the more or less disabled in the home, in the teaching institute, or in life at large.

One of the most interesting to public health nurses was that of the Infant Welfare Society of Minneapolis demonstrating the set up, equipment and program of the work for the well child. The set up was an actual clinic house with glass sides, easily accessible and visible to visitors. At noon each day a clinic was held — the mothers taking their children to the auditorium instead of to the clinic in the city where they would ordinarily go.

Fort Worth, Texas, will act as host to the Association in 1930.

The new President of the Association is A. J. Chesley, M.D.

The officers of the Public Health Nursing Section are:

Chairman—Grace Ross, R.N.
Vice-Chairman—Florence M. Patterson, R.N.
Secretary—Helen LaMalle, R.N.

Emilie G. Robson

We add a resolution of interest to our readers, adopted at this annual meeting:

Whereas, the American Indians are the most neglected racial group in the United States from the point of view of health protection, and

Whereas, Secretary of the Interior, Dr. Ray Lyman Wilbur, has requested appropriations adequate to provide for a reasonable degree of preventive and curative medical and nursing services for the Indian wards of the Federal Government, and sufficient to bring to an end the chronic undernourishment of many children in the Indian boarding schools, be it

Resolved, that the American Public Health Association endorses his request for appropriations for these purposes and respectfully urges upon the President of the United States, and upon the Committees on Appropriations of the Senate and the House of Representatives of the Congress the necessity of prompt and liberal provision of funds to prevent the further spread of preventable, and particularly of communicable diseases among the Indians, and to provide suitable and sufficient food for the Indian children.

Editorial Note: We hope to print a report from the Public Health Nursing Section in our next number.

Length of Visits in a Generalized County Nursing Service

By Laura A. Gamble, R.N.
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AND
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Cattaraugus County Department of Health, Olean, N. Y.

IN rural work, the generalized plan of public health nursing is commonly accepted as preferable to the specialized. Some of the advantages are obvious. When, as in Cattaraugus County, the nurse travels on the average more than 30 miles a day and nearly 8 miles for each family visited, there is no question but that, if she is qualified to handle all public health nursing problems which she encounters along the way, she will save much time. Certain other benefits are more intangible. The nurse who is conversant with all aspects of public health is a great asset to the rural community, where problems are as diverse as in the city but the organized agencies for dealing with them are much more limited.

There is another practical advantage. If at one visit, the nurse can extend her teaching to more than one patient, she saves time in a number of ways. Boiling one kettle of water instead of two, removing her hat and coat but once, even knocking on the door and entering—all these count in the long run. It seems reasonable to expect that the length of time per patient will depend to quite an extent upon the number of patients seen in a home. This was a point upon which the Cattaraugus County records could throw considerable light, so an analysis of the nurses' daily reports was made with that in mind. The results were interesting and presented one more reason why a generalized plan for public health nursing is to be preferred.

Evolving the Present System

In Cattaraugus County the generalized plan has been in use since the establishment of the County Department of Health in 1923. The Bureau of Nursing was organized practically in its present form early in 1925 with the family as a unit—one nurse only visiting the home and entirely responsible for all health problems coming within the field of public health nursing. Special supervision of the various problems was indispensable in the early days and gradually the number of experts on the supervisory staff was increased. A nurse in charge of nursing in the schools was first appointed, and was followed by a supervisor for the tuberculosis work. Other supervisors, for the most part themselves nurses, were in charge of the activities relating to communicable disease, including venereal disease, nutrition, maternity, infant and child hygiene.

As the work became organized, matters of technique and routine were worked out and established to the point where special supervisors were not so essential. Gradually the supervisory responsibility is being shifted to three senior nurses, under the guidance of an educational director of nurses and the nurse director of the bureau, thus extending the generalized plan to include the supervisory staff as well as the field workers.

The nurses work from six district stations, situated in the six health districts into which the county is divided, and within the boundaries of which they live. Each station is fully equipped for nurses' headquarters, clinics, classes, etc. The health districts are subdivided into smaller areas for each of which one nurse is responsible and which form more or less independent nursing units. These small

sections are under the supervision of the senior nurses, who are themselves in the field, each carrying a district of her own in addition to her supervisory duties in the two health districts assigned to her.

PERSONNEL AND PROBLEM

Throughout 1928, the average number of nurses in the field was 14, a figure which includes the three senior nurses. The population served by these nurses numbers 50,000. Included therein is a city of 10,000 in which the public health nursing work, with the exception of that in the schools, is carried by the county nurses. There are also 13 villages whose population ranges from 325 to 2,200. Eight of the nurses average 4,000 or more persons in their health units, one has 3,800 and five have less than 3,000—the health units with the smaller population being located in the more sparsely settled sections of the county. The county is some 35 miles square, giving each nurse an area the equivalent of nine or ten square miles.

In addition to their work in clinics, classes and schools, the nurses make on an average 6.6 visits to patients per day and see 1.7 patients per family. These figures do not include coöperative visits, that is, visits in behalf of patients but not to patients themselves or to someone acting for them, principally because coöperative visits are not classified in any manner. All other visits are placed under nineteen headings according to the type of problem presented and the age of the patient. For the purpose of this study the classifications are assembled in seven categories. The four headings termed "Infancy," "Preschool," "School," and "Adult" do not include visits relating to maternity cases or for the prevention and control of communicable diseases or tuberculosis. The visits under the heading "Maternity" include prenatal hygiene, delivery service and postpartum care. The headings entitled "Communicable Disease" and "Tuberculosis" include all visits for the prevention and control of these diseases regardless of age. Although visits classified for age are associated with visits arranged by problem, which appears somewhat like adding apples and pears, the main divisions of the work are adequately represented by this arrangement.

THE TIME ELEMENT

Under a generalized plan it is essential to have a line on the proportion of time devoted to each service. This distribution is based upon the time in clinics, classes and schools, and upon the visits, the latter being adjusted to allow for the fact that different types of visits consume on the average varying lengths of time. The types of visits frequently requiring bedside care, for example, consume much more time than those which are largely educational. There is in the county a definite need for bedside care, due in large measure to lack of hospital facilities. There is no hospital accommodation for communicable disease. As a result, from a fourth to a third of the nurses' time in visits is spent on bedside care. This has a material effect upon the distribution of their time. In giving nursing care, however, even when of an emergency nature, the educational aspect is stressed.

In 1928 the total time of the nurses was distributed as follows:

Maternity	12.3
Infancy	16.1
Preschool	11.2
School	20.5
Adult	16.4
Communicable disease	9.5
Tuberculosis	14.0
	100.0

MEASURING TIME ELEMENT PER PATIENT

The distribution of the visiting time by problem is based upon the experience during three months of 1928, when the nurses recorded the time taken by each individual visit, exclusive of travel time, in order that a reliable estimate could be made of the time required by the various types. A month in winter, one in summer and one in fall were selected for this test,

providing an average representation of conditions at different seasons of the year. It is not probable that this distribution will vary radically, unless a definite change is made in the policies and routine of the bureau, which are adjusted to the field needs as they are at present understood to exist. The reports covered 3,302 families, or 5,364 individuals.

After the material had been accumulated, it was decided to group all items according to the number visited in the family, in order to ascertain the precise effect the number of patients served in one home had upon the time per patient. It was found that when only one patient is visited the average number of minutes per patient is 25. The time decreases with the number of patients visited until in families with five or more patients it becomes eight minutes. The number of families in which more than five patients were seen is too small to be significant. The average number of minutes per patient, for all visits, is 18.

for the purpose of promoting the health of the entire family. They may be directed, for example, toward assisting the mother to plan a better balanced and more nourishing diet. If there are no particular members of the family for whose health the nurse is working, such a visit will be classified as a visit to one person. There are other factors as well, but these two were in the main responsible for the high proportion of single visits.

SOME VARIABLES

The prevalence of problems and age groups under which the visits fell varied considerably with the number of patients seen in a family. When only one patient was seen, visits to adults for general health and hygiene predominated. It had been known in the past that these visits consumed more than the average amount of time but the reason was not apparent until this study was made when it was shown that visits to adults for health

TIME PER FAMILY AND PER INDIVIDUAL PATIENT

Number visited per family	Number of visits to families	Average minutes per family visit	Average minutes per visit to individual
One	1990	25	25
Two	834	34	17
Three	326	34	11
Four	88	39	10
Five or more	64	47	8
	Total 3302	Group average 29	Group average 18

MORE WORK THAN MEASURES SHOW

Even in a generalized service the families in which only one patient was served predominated, 60 per cent falling in that group. At first glance, this is a rather startling proportion, but consideration of the causes places it in a different light. In the first place, initial visits are generally classed under the most obvious problem. The nurse does not attempt to discover all health deficiencies at her first entry but concentrates on meeting the immediate need and on laying a foundation for future contacts. In the second place, the classification of visits as carried out understates the work accomplished. Many of the visits are made

and hygiene are infrequently associated with visits to other members, 51 per cent of them being to families in which only one patient was seen.

Despite the fact that teaching relating to the precautions to be observed by the entire family was given on practically all visits to positive tuberculosis cases, more than half of them were classified as single visits under the heading of positive tuberculosis. The explanation is simple. The visit was not classified separately for other members unless the health condition of suspects or contacts in the home merited special attention.

The proportion of school and preschool visits, on the other hand, in-

creased with the size of the family, suggesting that visits to these two groups may at times be incidental to visits for other purposes.

Visits for delivery service averaged slightly over three hours apiece. During the periods covered there were fifteen such visits. Visits relating to prenatal care averaged thirty-one minutes each, and for postpartum care of mother, twenty-two minutes each.

With the exception of visits for communicable diseases, which varied with the nature and prevalence of the epidemics, the length of time taken by visits of different types was fairly consistent, both throughout 1928 and in previous years.

Since the average for maternity visits was high because of the time taken when delivery service was given, and since at the time of many visits for delivery, service to other members of the family was not given, it was thought advisable to tabulate the results with delivery service omitted. When this had been done, however, no essential difference was noted. The average time per visit became only one minute less per family and per individual and the relative length of visits according to number of patients was not materially altered.

As far as average time by type of visit in all sizes of family was concerned, maternity visits ranked highest with 30 minutes, and school visits lowest, with 12 minutes. When only one patient was seen, maternity and school visits were still at the two extremes, but maternity took an average of 36 minutes and school 19.

The accompanying table gives the average number of minutes taken by each type of visit, according to the number of patients seen in the family. When 5,000-odd visits are distributed among six classifications, and further subdivided according to the number seen in the family, the number involved in families with more than three patients is too small to be significant.

The foregoing analysis can make no pretense at measuring quality of work. This is a separate problem, to be approached from another angle. But when the amount of time required to cover a given field is under consideration, the economy of having a staff equipped to cope with all public health problems arising within a home is well exemplified.

AVERAGE NUMBER OF MINUTES FOR EACH TYPE OF VISIT

Type of Visit	Number of Visits	Average Minutes All Visits	Average Minutes According to Number of Patients in Family		
			One Patient	Two Patients	Three or More
Maternity	561	30	36	29	21
Infancy	996	20	24	20	15
Preschool	850	13	20	12	8
School	711	12	19	12	8
Adult	757	23	31	13	12
Communicable Disease	698	13	21	12	8
Tuberculosis	791	15	22	14	11
Total	5364	Group av. 18	25	17	10

Through an oversight the short-short story—*In the House with a Rose Garden*—published in our October number, page 521, was not credited to *The Gleaner*, Texas State Department of Health, as it should have been.

Nursing Problems in a Social Hygiene Program *

By Mary V. Pagaud

Superintendent of Nurses, Child Welfare Association, New Orleans, Louisiana

THE problems of the public health nurse have a common denominator with those of the diplomat. Neither may be told without endangering the chance for solution. Tact and discretion are prerequisites for all forms of nursing, but they function as the touchstone of success in the approach to the social hygiene problem. A nurse's privileged knowledge, both of her patient's needs and of the practical fashion in which the appointed agents of the community meet or fail to meet these needs, often presents her agency with a choice of dilemmas. The lack of a coördinated city-wide social hygiene program is a familiar problem in many nursing organizations.

In the formation of that program—and in its execution—what shall be the place of the public health nurse? Perhaps that is conditioned by the social and medical development of the community, but the public health nurse everywhere has an acknowledged obligation to place before the responsible element of the public the knowledge of health conditions which her wide and intimate nursing contacts enable her to see accurately and in perspective. Hers the opportunity and the responsibility. How is she meeting this?

One answer to that question comes by way of a confession from the Child Welfare Association of New Orleans, so little have we done either through our own agency or toward community organization. In our treatment of venereal diseases and in our contribution toward the formation of a social hygiene program in New Orleans, we have little to our credit but the desire to assume a consciously neglected responsibility.

THE PROBLEM IN NEW ORLEANS

Yet we have not been unaware of the prevalence both of syphilis and of gonorrhea among our families, and particularly among the negroes under our care. Out of 300 of our negro maternity cases to whom routine Wassermann tests were given, 168 came back positive, and of these 151 were three plus or more. Only 44 per cent of the group were negative. Unfortunately, routine smears were not made but the number of one child negro families in New Orleans is an index to the prevalence of gonorrhea among the race.

Among our white maternity cases the rate is much lower, but still too high. Out of 1,000 white maternity patients delivered in 1928, 70 were positive for syphilis, and gonorrhea was found in 23 instances. This gives a higher rate both for white and for colored than the vital statistics of the City Board of Health would indicate—but the failure to report, the failure even to give a frank diagnosis to the family, are dual problems which must be faced by the public health nurse.

Because of the failure to report, the very scope of the problem must be estimated out of a nurse's empirical knowledge or through the secondary testimony of mortality rates in diseases resulting from syphilis.

Because of the failure to give a frank diagnosis, the scope of her nursing services are needlessly restricted.

Nurses everywhere, in their work with private physicians, have been called in to give treatments for gonorrhea considerately diagnosed under some other label. When the attending physician examines all contacts, we may agree to the new label with good

* This article is being published simultaneously in the November *Journal of Social Hygiene* by the American Social Hygiene Association.

grace, but where he fails to share our family-wide responsibility, the situation becomes needlessly difficult for the nurse and dangerous for her patients. Tactful inquiry among the family and tentative suggestions to the physicians are not always fruitful.

In New Orleans, secondary testimony to the prevalence of venereal diseases is available in the mortality rates from heart disease. In 1928, out of an estimated population of 440,000, there were 2,208 cardiac deaths, exclusive of deaths from arterial conditions. This gives a rate of 500 per 100,000. We do not know how many of these deaths were indirectly due to syphilis, but the population in the heart ward of a local hospital in 1928 numbered 1,163, of whom 209 were luetic. The index is probably not without significance.

We do not question the seriousness of the venereal disease problem in New Orleans, but we have little definite information regarding the prevalence of the disease—and definite information is needed before concerted action can be secured. But this information is in sight if not in hand. The Health Committee of the Central Council of Social Agencies, at the request of the Child Welfare Association, is discussing with the American Social Hygiene Association the possibility of a survey in New Orleans. Perhaps, on the basis of this hoped for assistance, we shall be able to plan for a city-wide effort to control venereal disease.

PRESENT PROGRAM

At present, however, the Child Welfare Association is working in a detached and ineffectual way to lessen syphilis and gonorrhea among our patients, particularly among the women under our maternity service. Because this service supplies both physician and nurse, it is possible for us to require routine smears and Wassermanns for all prenatal cases. For the detection of gonorrhea we are using the usual four-slide smear. Treatment is instituted at once for positive cases. But after the baby is delivered the mother is merely "advised" to report to some hospital clinic for further treatment—and all too frequently it happens that she never reports or fails to continue treatment. If she becomes pregnant again and returns to the Child Welfare Association for maternity care, treatment is resumed, but the valuable interval between pregnancies has been wasted.

The same futile cycle has been followed in the treatment of syphilis. Wassermanns are made routinely and in some instances treatment is given on clinical evidence even after several negative Wassermanns have been obtained. If the Wassermann is less than two plus, treatment is not given unless indicated by symptoms or by medical history. If the Wassermann is returned two plus or more strongly positive, treatment is given even if a repeat Wassermann is negative. Whenever a patient has been treated during a previous pregnancy, treatment is resumed even if the new Wassermann is negative—unless the patient has received adequate anti-luetic treatment following the post-partum period. But this is rare—too rare.

Wherefore we admit that we are accomplishing little in the control of the venereal diseases. For more than a five-year period we have tried to send our venereal disease cases into some hospital for treatment, but our records show that only 9.6 per cent registered with the hospital and less than 1 per cent have continued treatment until discharged. This has decided our maternity department to give continued treatment to former maternity cases in our own clinics. The results of this effort are not yet tabulated, but we know that a discouragingly small number are receiving adequate follow-up care. This is largely our own fault. We have not had a nursing staff large enough to permit us to substitute the energy and intelligence of the nurse for the lack of energy and intelligence in the patient. Nor have we been able to extend the scope of the nurse's influence to include fathers, yet even though we are

not unaware that to insist upon sustained treatment for the mother while the father goes untested and untreated verges on the prodigal.

REACHING THE FATHER

To reach the father, to give him an opportunity to share directly in the health instruction we have been giving the mother and in the health service now open to the other members of his family, is a planned for hope of the Child Welfare Association. Just as soon as the present pressure on the nursing staff can be relieved, we expect to ask each nurse to spend one evening per week visiting her families—with the expressed purpose of meeting the father, becoming aware of his health problems, asking his approval and assistance in our plan for his family. Evening visiting will lead to evening clinics, preferably worked out in conjunction with some hospital, but held in our neighborhood centers with our nurse to assist the physician.

These clinics, like our pediatric and maternity clinics, will treat only a limited number of patients during any one clinic period—thus insuring unhurried and unfatigued service to the patient and saving him carfare and needless waiting. They will be discovery clinics where venereal diseases and many other pathological conditions will be treated. Of course, it will sometimes be necessary to refer acute cases to a day clinic for extended examination or special treatment, but these night clinics will endeavor to save the worker the loss of a day's pay while he secures the medical care that will make or keep him well.

We are not blind to the difficulties involved in the plan. It will not be easy to interest the men in their own health—to the point where they will be willing to consult our physician. Some will resent the routine Wassermann and smears. Social problems will follow on the heels of medical problems. But problems are the familiar antagonists of nurses and we are ready to make the effort. If we win the confidence of the fathers and secure their attendance at these clinics, we shall have completed the cycle for family health work.

EQUAL RESPONSIBILITY

At present we recognize that we are placing an unfair responsibility upon the women in expecting them to convince their husbands that treatment, particularly the treatment of venereal diseases, is necessary. These men have never had the opportunity to share directly in the health teaching that has been given so freely to their wives; they have not been directly consulted by the nurse in her health plan for the family; unintentionally, we have encouraged them to feel that our services have been intended for women and children only—except, of course, when some devastating illness makes bedside care necessary. Even then the nurse frequently has to win the confidence of the man and make him understand that care to him is a legitimate nursing activity! We have been blind—and strangely indifferent to a potentially strong ally.

But even if we are able to realize this still nebulous hope of medical and nursing supervision to fathers, if we can increase our home visiting and secure the continued treatment to luetic mothers and children, we shall still be meeting only a limited part of a city-wide need for social hygiene. While hospital clinics treat a syphilitic patient for a fractured arm and ignore the syphilis; while private practitioners can withhold diagnosis and limit their services to the individuals under their care; while prostitution flourishes openly and almost uncontrolled—no single agency alone can cope with the racial menace of venereal disease. City-wide education, determined and coördinated effort, will be required to control what is perhaps the greatest single cause of congenital deaths among children, of invalidism among mothers, and of a short and lowered earning period among fathers.

Control of Venereal Disease in Prenatal Patients

DURING the past five years 10,060 pregnant women were cared for at the clinics of the Detroit Department of Health, of whom 1,060, or 10.5 per cent, were syphilitic. Of this number 28 per cent received a full course of treatment at the Venereal Clinic. The high incidence of the disease is largely due to the fact that 57.4 per cent of the clinic patients were colored women and 13.4 per cent of these were syphilitic.

In the past year 52 per cent of the syphilitic cases at the clinic received a full course of treatment. In the years 1924–28 inclusive, for those having no treatment, the still-birth rate was 240.3 per thousand, for those having partial treatment 131.8, while for those having at least one full course of treatment the rate was 63.6.

Blood Wassermann tests are made on all women who are admitted to the prenatal clinics. Almost all luetic mothers come with no subjective symptoms and do not suspect that they are luetic. Even with negative blood Wassermann reports a number are diagnosed by means of history and clinical findings.

When a positive diagnosis of syphilis is made, the expectant mother is sent to the special Venereal Clinic maintained by the Department in order that intensive treatment with arsphenamine may be begun at once. The treatment is given according to a specified routine and is continued until the time of delivery. It consists of injections of neosalvarsan and a mercurial preparation given at weekly intervals until eight doses of neosalvarsan and twelve doses of the mercurial preparation have been given. Treatment is started regardless of the period of pregnancy, but it is most desirable to start treatment within the first sixteen weeks because it is believed that transmission occurs only through the placenta, and that a minimum of three months is required for that transmission. As the efficacy of treatment is being emphasized more all the time, the number who receive treatment early in pregnancy is increasing.

TEACHING THE PATIENT

During the attempt to prevent transmission of syphilis to the newborn, the mother is taught the danger of syphilis, the possibility of transmission and the need of thorough treatment to produce a cure. The examiner in the clinic always makes a special effort to point out also, to the mother, the very urgent need of examination for all members of her family, and to explain the disease to her in so far as she is able to understand.

Nurses visit the mothers regularly in the homes to explain why they should return to the clinic for treatment; to emphasize again the dangers of syphilis; the disastrous results to the newborn of no treatment or of insufficient treatment and the benefit to the mother and to her family of regular and sufficient treatment. The nurse makes every effort to have all members of the family examined either by a private physician or by a clinic physician, and to have the mother return for examination with the baby about six weeks after confinement. Any mother with whom the nurse comes in contact, who gives a history of premature or still-births is prevailed upon to present herself for a blood examination.

Classes are conducted for prenatal mothers in the clinics, part of the discussion being on social hygiene. Every effort is made by the examiner in the clinic and by the nurses whether in the field or in the class-room to make the instruction convincing, and to couch it in such vocabulary that the mothers may be made to understand fully the dangers of the disease; that transmission can be prevented, and that a cure can be produced only through treatment.

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Dental Clinics in a Rural County

By Ellen C. Perkins, R.N.
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Waiting Their Turn

MANY lay people ask me what I find to do after the schools close for the summer vacation. I always tell them it is my busiest time of year. Between running clinics, entering children at the Health Camp, correcting defects and reaching farms which are inaccessible in spring and winter, I have more than enough to do.

My territory covers six towns in Eastern Franklin County, excluding the town of Orange, where I make my headquarters. This area is extremely rural, with farming and lumbering the principal occupations. I have twenty schools with a school population of approximately six hundred children.

The dental work this summer was more successful than last year. Instead of ten weeks with one dentist working, as I had last summer, I had ten days of intensive work with two dentists working together.

After raising a guarantee fund in each town where we were to work, which would cover the charity and semi-charity cases and the cost of dental supplies, and engaging two excellent dentists who dared to brave such remote little villages for the sake of adventure for two weeks, I started in with preparations. I got out my publicity a short while before clinic time so that people would have the plan fresh in their minds. Most of it was done through "ads" in the local papers.

The ideal time to examine children's mouths is of course before the closing of schools in rural districts, because you do not have the great problem of transportation to deal with. But I was unable to get dentists before the end of the school term and therefore had to make the best of it.

My entire time was given to clinic instead of going out in the field. I emphasized promptness at clinic and made the people feel that it was an expensive, worthwhile undertaking which should be well patronized in order to reduce the cost to the community. No adults were admitted as patients. I had a big strong boy in each town responsible for hauling water, emptying pails and running errands. The dental chairs, foot engines, etc., were borrowed from my Red Cross Chapter, the State Department of Health, and a neighboring County Extension Bureau. The dentists brought their own instruments and ordered dental supplies. Paper napkins were given us by a local paper mill.

Our schedule was somewhat as follows:

Night before a clinic: Equipment packed in nurse's car

Clinic Day: 8:00–8:30 A.M.—Leave Orange (depending on distance to cover)
8:45—Arrive at place for clinic; find patients waiting on the steps of school house, Town Hall, or church where we worked
8:45–9:00—Set up equipment and give appointments to patients
9:00—Start work
12:00–1:00—Dinner at some near-by farm house or picnic in cool pine woods
1:00–1:30—Set up equipment and line up patients
1:30–4:00—Work (all extracting done last thing in P.M.)
(3:30—If last day in a town, nurse starts packing equipment in car)
4:15–4:30—Leave town for Orange

We were fortunate as to weather with only one rainy day the whole time. The response was very gratifying after last year's struggles. The many children lined up on the steps as we approached, a school committee member offering to drive around to "drum up trade," a child of eight walking

several miles in the hot sun alone to clinic, and the many visitors, were all signs of the growing interest in the dental work.

Next year we hope to have a grammar school girl in each town act as hygienist, for a girl of that age can easily mix amalgam fillings and make cotton pledgets, etc., for the dentists.

Fitting in Blueberry Time

Running a dental clinic sounds easy, but I found that the only way to make it seem so was to run one for a year as an experiment and then profit by that experience the next. The problems of transportation and proper publicity are so great in the country that an enormous amount of preparation has to take place before things are under way. One must adjust the clinic to the conditions in each separate town. Haying time when all hands are at work, Old Home Days and County Fair Days must be avoided. I found that if clinic was held during blueberry time the mothers were more easily persuaded to send the children because they have more ready cash at that time. Most of them are anxious, like the rest of us, to pay for what they get. Those who came from long distances and large family groups were urged to make a day of it and bring their lunch.

It is encouraging to know that at last rural school children are beginning to receive some of the advantages that urban children have had for a long time. There is yet a large field open for dental work and hygiene, but when our problems of poor roads and lack of transportation are overcome, we will have gone a long way toward our goal.

CINDER TEA

Our English sisters have an enviable ability to translate the everyday experiences of a nurse into dramatic literary form. We offer this brief tale as evidence:

Mrs. A. was young and small and untidy and, alas! very stupid. She had two children, one weedy little boy and a rather dismal new baby. When I visited her she was feeding the baby herself. After a little persuasion she consented to come to the clinic; she had been there with the first baby, and knew all about it.

She duly arrived, and walked into the doctor's room with her mouth a little open, her hair a little down, her whole appearance rather helpless, and the baby looking much worse than when I had last seen it. It had been a long and trying afternoon, and our good doctor's nerves were becoming a little frayed with demands for free milk. He looked at her, and his eye did not light up.

"Well," said he, "and what have you come to the clinic for, Mrs. A.?"

"A box of food, doctor."

"Oh, you haven't come for advice, then?"

"Oh, no, doctor"—in a shocked voice.

"Just come for what you can get?"

Mrs. A. looked delighted; never before had she been understood so well. "That's right, doctor," she said gratefully. I began to feel a little nervous.

"Well, let me see the baby."

The baby was shown, with its clothes that were not really dirty and not really clean and its rather pinched little face. "How often do you feed her?" asked the doctor.

"Twice a day," replied Mrs. A.

"What else do you give her?"

"Cinder tea," with a certain pride.

"Oh, and what do you give cinder tea for?"

"The wind," bleated Mrs. A. "The woman in the house told me to give it."

"Well, next time you make cinder tea, take it yourself, and when you taste it you may not be so eager to give it to the baby." Then the doctor turned to me. "Two feeds a day supported by cinder tea does not sound very creditable. Who visits this woman?"

"I do. And I think the two feeds mean bottle feeds; the others are breast. You feed your baby yourself, don't you, Mrs. A.?"

"Oh yes, Miss. I gives two bottles to make out, as I don't think I satisfies her."

"The cinder tea is an innovation since I last visited," I said meekly.

Our doctor was a little mollified and, after a few simple and clear items of advice, Mrs. A. was dismissed, hugging her "box of food"—and I drew a breath of relief. The way of the health visitor is sometimes a hard one. *E. R. W., The Nursing Times*

Study of Chronic Cases

CARRIED ON BY THE JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY AND THE COMMUNITY HEALTH ASSOCIATION OF BOSTON, MASS.

By Sophie C. Nelson

Director, Visiting Nurse Service, John Hancock Mutual Life Insurance Company

LAST year, through a special arrangement with the Community Health Association of Boston, a special study was made of service to chronic patients in Boston. This study was terminated in 1928, and the findings were compared with a control group of six organizations, whose total quantity of service equalled that of Boston, and with the John Hancock Insurance Company service in general. Because the findings were practically similar in all three groups studied, our conclusions are based on the general service rather than on the specific study.

A chronic disease is generally understood to be a pathological condition that lasts more than three months, that definitely interferes with customary and normal daily activity and in which the problem of medical and nursing care is dominant. Chronic cases may be divided into three groups:

The quiescent or dormant cases—where the routine daily care necessary for the comfort of the patient does not require skilled nursing care. Untrained help may be utilized if given instruction and under supervision.

Improvable cases—where skilled nursing care and the intelligent administration of treatment contribute to the improvement or ultimate recovery of the patient.

Acute conditions and advanced cases—where skilled nursing care minimizes suffering of the patient, relieves anxiety and nervous strain of family, and should function the same for these as for other acute cases.

OBJECT OF THE STUDY

In providing any nursing service, our desire is naturally to try to give service adequate to the need, compatible with what we believe to be our responsibility and contingent upon expense. In making a policy relative to chronic care, our effort was to try to provide a service stringent enough on one hand to safeguard a terrifically large demand for the first group named, elastic enough to be of value to the second group, and humane enough to function for the third group.

Our study was precipitated as a result of insistent demand for more and more service to chronic cases. We wished to substantiate on the basis of specific information whether our present ruling was satisfactory, or whether we should make a new one.

We were anxious to determine whether or not there might be a specific age group (the young) to which we might offer a very constructive service which was more liberal than our present policy. We wondered if there might not be a certain disease group for which more service might be available in relation to offering a scientific contribution to the cure or retardation of that disease. We were further interested in determining what the ultimate result or prognosis of our chronic cases was and what disposition was made.

FINDINGS OF THE STUDY

Our findings indicated that we took care of more females than males. This was expected because our whole service, as does all visiting nurse service, functions for many more females than males, especially after the child-age period. Our service was given more in the age groups of forty-five to sixty-five and sixty-five and over than any other age group. A considerable amount of chronic disease, however, was found in young persons. The ma-

jority of patients had been ill over three months before service was asked for.

The diseases for which the largest volume of service was given and consequently for which extended service is frequently requested, are as follows:

Diseases of circulation, including heart or heart affections.

Nervous disorders, including cerebral hemorrhage and apoplexy.

Cancer.

Tuberculosis.

The largest number of visits was made to cancer cases. In the differentiation between operative and post-operative cases, the largest number of visits was made to post-operative cases with the most favorable prognosis. Our findings indicate that service was requested for the usual so-called "chronic" diseases, and the four above-named diseases account for 75 per cent of the cases.

The majority of cases was discharged unimproved or dead, showing that, although unlimited care might be given as was the instance in Boston, the outcome is the same. The disposition of cases is noteworthy. A fair proportion was sent to institutions, about 20 per cent in our service in general and practically 45 per cent in Boston, which probably has better institutional facilities for care of the chronic sick than any other city in the country. Practically 20 per cent was dismissed to the visiting nurse associations and received continued care under their supervision.

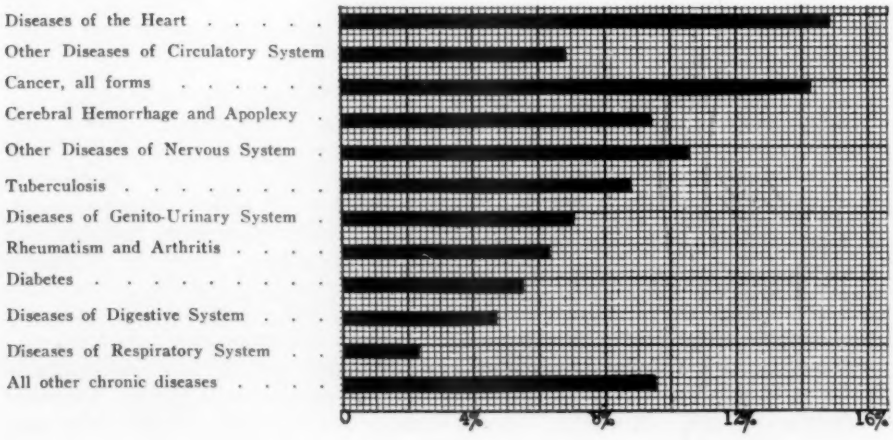
CONCLUSION

In short, although the question of adequate care to chronic cases must be given consideration and reconsideration from time to time in view of the changing information relative to more favorable prognosis of certain diseases, for the present it would seem that our policy of giving very limited care generally to chronic cases with the hope that the nurse may teach some member of the family how to give the routine care, is the most expedient.

Our findings would indicate that most of the service is given to those diseases definitely termed "chronic" and to which nursing makes a humanitarian contribution but hardly a scientific one. Our present policy limits very definitely the service, but does, however, offer us the possibility of giving additional service at the request of the nurse to specific cases. Our decision about the amount of service given is based on the disease diagnosis and the prognosis.

PERCENTAGE DISTRIBUTION BY DIAGNOSIS OF 3869 CHRONIC CASES CARED FOR BY THE JOHN HANCOCK NURSING SERVICE—1927

(Exclusive of Boston)



Report of the Committee on Psychiatric Social Work in Public Health Nursing Agencies *

MENTAL hygiene programs are being developed by several public health nursing organizations in connection with and as a part of their regular nursing and health services. As a result of this new development, many challenging questions have arisen. Just what rôle should the public health nurse be expected to play in the field of mental hygiene? Of what practical value is a mental hygiene program to a public health nursing organization? What should be the methods and aims for promoting such a program? What are the duties of the mental hygiene supervisor? Such questions as these are of interest not only to those responsible for the administration of public health nursing but also to those concerned with the possibilities for the extension and utilization of the principles of mental hygiene.

SPECIAL STUDY COMMITTEE

In recognition of the need for a detailed study of the mental hygiene programs of the various health agencies, a special committee for the study of psychiatric social service work in connection with public health organizations has been appointed by the American Association of Psychiatric Social Workers. The members of the committee consist of the mental hygiene supervisors of public health nursing organizations which have already adopted mental hygiene programs. The organizations represented on the committee are as follows: Association for Improving the Condition of the Poor, Henry Street Visiting Nurse Service, East Harlem Nursing and Health Service, all of New York City; the Infant Welfare Society, Chicago; the Community Health Organization, Boston; the Visiting Nurse Service, Minneapolis.

As a means of ascertaining what these various organizations are including in their mental hygiene programs, the committee voted to request each member to write a job analysis of her own position as mental hygiene supervisor. The following outline was suggested for the analyses:

I. Type and purpose of organization
II. Type of personnel (including title and staff position of mental hygiene supervisor and assistants)
III. Duties of mental hygiene supervisor
    1. Administrative
        a. Office management
        b. Clinic management
        c. Coöperation with other agencies
        d. Publicity
    2. Case Work
        a. Purpose
        b. Number and type of cases carried
    3. Consultation Service
        a. With staff
            Regarding their patients' problems
            Regarding their own personal problems
        b. With patient
            Office interviews
            Home visits
        c. With others
    4. Educational Work
        a. With staff
        b. With patients
        c. With others
    5. Miscellaneous Duties (not above classified)

THE SUPERVISOR

In every organization studied, the energies of the supervisor are directed primarily toward educational work with the staff. Social case work and consultation service are also very important components of the mental hygiene supervisor's responsibility; they are of the greatest value, not only where the welfare of the patient is concerned, but also for the first-hand material thus obtained for teaching purposes. Actually, the case work

* Presented at Annual Meeting of American Association of Psychiatric Social Workers, San Francisco, June, 1929.

COMPARISON OF DUTIES OF MENTAL HYGIENE SUPERVISORS IN SIX PUBLIC HEALTH NURSING AGENCIES

Based on Committee's Job Analysis

Duties	Minneapolis Visiting Nurse Service	Community Health Organization—Boston	Infant Welfare Society of Chicago	Henry St. Visiting Nurse Service—N. Y. C.	Association for Improving the Condition of the Poor. N. Y. C.	East Harlem Nursing & Health Dem.—N. Y. C.
	40 nurses.	150 nurses. 7 dieticians. 3 mental hygiene workers.	40 nurses. 13 dieticians.	210 nurses.	60 nurses.	25 nurses. 4 nutrition workers.
Administrative	Supervision of method of case referral. Coöperation with other agencies. Special services re: commitments.	Full responsibility for planning mental hygiene program with coöperation of Director and Mental Hygiene Committee of Board Members, including educational plans and coöperation with all psychiatric clinics and agencies.	Attendance at 18–20 conferences per month for infants, preschool, and pre-natal work. Coöperation with psychiatric agencies.	Planning entire mental hygiene program. Coöperation with psychiatric clinics and social agencies. Member of Executive Staff Committee of Henry Street Nursing Service.	Preparation of clinic schedule. Coöperation with psychiatric agencies. Special service on committees.	Planning of record forms. Management of clinic sessions, selection of cases for clinic. Coöperation with other agencies.
Publicity	General publicity avoided. Talks to outside groups and occasional short articles written.	Prepares monthly report for publicity committee. At special times, presents cases or striking material which is used by publicity committee.	Talks to outside groups. Posters prepared, articles written.	Prepares monthly report which is available to publicity committee.	Writes some case stories at request of publicity writer. Work regularly done by paid publicity.	Responsible jointly with psychiatrist and director for publicity re: mental hygiene program.
Case work done by Supervisor alone	Because of local situation, necessary for supervisor to herself carry out case work plans. 116 cases referred to her in 16 months service.	Some careful case work is done for teaching purposes when no clinic or hospital is carrying the case. Cases divided into 4 groups: Children, Adolescents, Pregnant women, Adults. 1928—932 cases referred, 719 closed to hospital clinics or private psychiatrists, 239 carried solely by staff of organization.	Cases carried for demonstration material or for short period of intensive work. First year of service carried 16 cases—now reduced to 2.	No case work but careful supervision of cases carried by nurses. 1928—709 cases carried, 469 closed at end of year, of which 237 were supervised in home by nurses without reference to a clinic.	Case work done where intensive psychiatric social work required and worker's case load is heavy or for demonstration purposes. Average load 6 to 10.	None.
Consultation Service a. Staff	Average of 8⅔ hours per week with staff nurses re: patients' problems. No recognition of consultation with staff on personal problems though it has played important part.	Nurses have free access to psychiatric social worker re: discussion of patients' problems; definite days at each of 14 district stations—1 worker for 7 districts. Nurses encouraged to make special appointments regarding their own problems.	Frequent visits to various stations for case discussion. Files checked through at intervals, records which need mental hygiene service discussed with worker.	Bi-weekly conferences in each of 16 centers. Conference lasts 1 hour, divided between formal talk and case discussion. Staff discusses personal problems with worker. This phase of work growing in importance.	Workers come voluntarily or at supervisors' request to discuss case work problems. Some workers come voluntarily to discuss own problems. Supervisor discusses difficult staff problems.	Major part of time spent in informal staff consultation on problems of patients and of staff. Consultant on social problems, not all primarily psychiatric.
b. With patient	Office visit with working people or where home visit is unsatisfactory. Home visit is made with nurse and alone.	Office interviews. Home visits, during first 2½ years. Attempt made to visit every patient referred. First visit made with nurse referring case.	Interviewing with mothers at regular clinics. Home visits with worker on all cases referred before treatment is planned.	Office interviews with patient or relative at request of staff nurse. Home visit to size up situation with nurse. Recognized as valuable as educational factor.	Patient brought to office by regular worker. Home visits made at request of worker or with worker. Policy to visit every clinic case.	Patients interviewed at office in nurse's absence. Home visit made with nurse on emergent cases. Special service in association with psychiatrist to group of expectant mothers.

c. With others	Other agencies.	Other agencies — Board members.	Other agencies.	Other social agencies. As member of Advisory Nursing Committee of Joint Vocational Service interviews applicants with personality problems.	Other agencies — Community Church because of affiliation with organization clinic.	Other agencies.
Educational Work a. Staff	Beginner's class, nurses on staff less than 6 months, 8 lectures, 1 hour a week. Advanced groups, nurses on staff more than 6 months—discussions more informal, 1 hour a week. Supervisors group meets only twice a month. This year requested review of books. 1 regular staff nurse assigned to mental health department for full time.	Intensive course of 9 lectures in mental hygiene given twice a year to new nurses with written quiz at end. Individual conferences with nurses regarding their own or their patients' problems. Compulsory reading list. Talks every 3 weeks in 14 stations on some phase of mental hygiene. Selected groups of nurses given special course of 1 month in central office directly under mental hygiene supervisor.	As a part of 2 months training course for new staff workers, 1 day given to discussion of mental hygiene program — 1 day spent at preschool branch of Institute for Juvenile Research; 1 day in visiting nursery schools and second month in practice work. Informal round table discussion with the staff based on suggested references or on subjects closely related to problems referred by the the staff.	Bi-weekly conference in each center office attended by center staff—1 hour talk by supervisor on special phase of mental hygiene, case discussion. Individual conferences with nurses. Selected reading list. Criticism of histories. Course of 10 lectures on mental hygiene for each new group. Field trips to institutions.	Group conferences. Past winter's program has covered symptoms of functional psychoses, 2 workers detailed from staff for 3 months' special training each. Reading suggestions made through staff bulletin. Reading required of worker in training. Two classes of new nurses once a winter, 6 to 9 lectures.	Group conferences with staff combining theory and case discussion. Supervision of record writing. Individual conferences. Studies of apparently well adjusted families as well as those with definite problems.
b. Patients	None.	12 mothers' clubs for pregnant women. Of series of 10 lectures to prenatal patients, 2 are given by mental health workers. 1 club in Italian district for young mothers, 2 talks on child training. Fathers' club—1 talk on fathers' part in child training. Conferences with patients by appointment.	Group talks to mothers on habit training. Lantern slides used. Printed slips prepared on toilet training.	None.	None.	Discussion with mothers' club on subject of answering questions of children about sex.
c. Others	Supervision of practice work of students from University of Minnesota School of Social Work.	Interpreting special work to other social agencies. Service on Mental Hygiene Committee. Outside speaking. Instructor in Simmons School of Public Health Nursing. For 1929–30, appointed with a psychiatrist as a special instructor for a required course in mental hygiene in the Public Health Nursing Department at Simmons.	Talks to classes of nurses at University of Chicago and Illinois Training School for Nurses.	Occasional talks and lectures to outside groups, including students from Teachers College, Columbia, and senior nurses in hospital training schools who affiliate with Henry Street for field experience of 2 months. (86 in 1928.)	Practice work supervision of New York School of Social Work students.	Talks to school nurses at Teachers College, supervision of a limited number of students from Teachers College taking field work in Social Service. Conferences with other visitors and students.

done by the supervisor herself, or carried by the nurse and directed by the supervisor, forms the backbone for the educational program. Theory cannot be discussed fruitfully aside from illustrative material, and the cases known to the nurses themselves offer the best opportunity for discriminating discussion.

EDUCATIONAL METHODS

The educational work with the staff is accomplished by various methods, of both the formal and informal type. The methods used most frequently and found to be of value are as follows:

1. Formal required lectures
   a. Introductory course of lectures to new staff members
   b. Lectures by some authority outside the organization, usually by a psychiatrist
2. Informal conferences and case discussion with
   a. Groups of nurses, *e.g.*, a conference held at regular intervals in the center office
   b. With the individual nurses in regard to a special case or problem in which she is interested
3. Reading lists
4. Field trips to state institutions, special schools, mental hospitals, etc.
5. Assignment of individual nurses for full-time experience under the supervision of the mental hygiene supervisor for a definite period—usually for 1 or 2 months
6. Visits made in the homes with the nurse in which the mental hygiene supervisor either demonstrates an interview or observes the one conducted by the nurse

Educational work with groups of patients has been limited in most of the programs by lack of time on the part of the supervisor. In Boston, however, where the mental hygiene staff is larger, considerable work has been done with the Mothers' Clubs and other patient groups. Indirectly, by teaching the nurse who conducts group health activities, the supervisor reaches the patient.

From discussing her patients' problems with the supervisor, it is an easy and natural step for the nurse to ask for advice and guidance about her own perplexities. Without an exception, all of the supervisors have been called upon frequently for help by the members of the staff. Usually no formal record is kept of these personal contacts with the staff members, such interviews being treated as confidential.

METHODS OF CASE WORK

The amount and type of case work done by the mental hygiene supervisor herself, and the amount of supervision she gives to the case work of the staff nurses, depends, first of all, on the number of nurses she has to direct. Secondly, on whether she makes use of the clinical resources available in the community as has a psychiatric clinic connected with her own organization with which the staff is more closely associated than is possible with a clinic outside the organization. Three main methods of case work appear in the job analyses under discussion:

> The supervisor acts as consultant only: the nurse is responsible for discovering problems, discussing them with the supervisor, carrying on treatment in such mild and incipient cases as do not require clinic referral, and referring the more serious and complicated cases for clinic examination and treatment. Conference with the individual nurse in regard to her patients helps clarify the various aspects of the particular problem and leads to the formation of some suitable plan of action.
>
> The supervisor acts as consultant and, in addition, carries a few cases for demonstration and teaching purposes.
>
> The supervisor carries some cases for demonstration purposes and has assistants who have had special psychiatric social service training, who carry the case load for such problem cases as the nurses find and refer. The nurse's function here is chiefly to act as a "scout" who ferrets out the mental problems in the community.

CONCLUSIONS

It is significant that six workers on the staff of agencies as widely separated in policies and standards as in geographical location, should have inadvertently arrived, without guidance or precedent, at nearly similar standards, aims and functions.

They seem to be in complete accord in placing the emphasis of their job upon staff education rather than upon their own performance of intensive psychiatric case work. The mental hygiene supervisor sees staff education not only in terms of training the public health nurse in an awareness of mental hygiene problems among her patients, but in a recognition of the rôle the nurse's personal problems may play in her ability to transmit adequate standards of mental health to her clientele.

The mental hygiene supervisors seem also to have arrived at a mutual understanding as to the value of their particular contribution in the general program of a public health nursing agency. They recognize that, in order to be effective, this program must be on a sound practical basis, planned so as to serve the needs of the specific agency and sufficiently flexible to adapt itself to the quickly changing and often urgent demands of any generalized nursing service.

The mental hygiene supervisor realizes, probably better than any person either outside or too closely within the bounds of that agency, the strategic position the public health nurse holds for disseminating mental hygiene principles. The nurse has access to the pregnant woman, the preschool child, the juvenile and adolescent groups, and the neurotic adult. Properly informed, she can be a preventive force of inestimable value to the community. There must be considered, however, the very practical question of how many burdens can be reasonably placed upon her shoulders. Will she not reach a saturation point in the responsibilities she can carry? Is the increase of neuroses and insanity so grave that mental hygiene warrants being given temporary prominence over physical care, or should the tenets of mental hygiene be allowed to permeate slowly the whole health program? These and many other questions present themselves for analysis out of the beginnings that have already been made.

The Standing Committee on Mental Nursing and Hygiene, appointed by the International Council of Nurses a year ago, met for the first time at the I.C.N. Meeting in Montreal.

The program of the Committee for the next four years, as outlined by Karin Neuman-Rahn of Finland, Chairman of the Committee, is:

To secure the compulsory inclusion of mental nursing and hygiene in the curricula of all schools for nurses.

To encourage the various countries to arrange for postgraduate courses in mental nursing and hygiene and to secure the inclusion of this subject in postgraduate courses for public health nursing.

To get courses for administrators and teachers in this field arranged at universities or elsewhere.

To get all affiliated and associated members of the International Council of Nurses to appoint representatives or corresponding members of the committee.

To try to get the national organizations to form national committees on mental nursing and hygiene.

To get the chairmen of these committees made official members of the national committees on nursing education.

To maintain contact between the national committees by sending out circular letters which can be discussed, criticized, and thus help to develop new ideas and bring about new suggestions, these to be returned to the chairman and then to be studied, assimilated, restated, and returned to the members of the committee.

REPORT ON MENTAL HYGIENE CASES

HENRY STREET VISITING NURSE SERVICE, NEW YORK CITY
APRIL 15, 1928 TO APRIL 15, 1929

We quote from the report of the mental hygiene supervisor:

The total number of mental hygiene cases handled during this last year by the Henry Street nurses was 709, of which 240 are still active. This indicates an increase of a little over 75 per cent in number of cases handled in comparison with the figures for the same length of time, from April 15, 1927, to April 15, 1928, the first year of Henry Street's mental hygiene program. This current report deals only with an analysis of the 469 closed cases.

Of these 469 cases, 241 were male and 228 female.

Classified according to age groups:

1 to 5 years	113
5 to 12 years	191
12 to 16 years	44
Over 16 years	121
Total	469

Of the total number of closed cases, only 121 fall into the adult classification of over sixteen years of age. This represents 25.7 per cent of the total number of cases, indicating that the nurses are continuing to do most of their mental hygiene work with children, which is the period when the most valuable preventive and constructive work can be accomplished.

The above figures show that 52.3 per cent of all the mental hygiene cases have to do with native born persons of native born parents, although the general statistics of Henry Street Nursing Service show only 26 per cent in this same group. It is probably true that the educational level in these American homes is higher than it is in the average foreign home in New York City with whom the visiting nurse has contact, with the result that the parents are more interested in what assistance mental hygiene methods may have to offer them in the care and training of their children, and in the correction of their undesirable habits. There is no language difficulty in these American homes, which makes it easier for the nurse to discuss mental hygiene problems with the parents; language difficulty is frequently a factor in closing a case, with the notation, "mother uncoöperative." The mother may not have wished to be uncoöperative, but she has not understood what the nurse was talking about.

Of the 237 cases handled by the nurses in the home without referring the patient to a psychiatric clinic for examination, 178 made a satisfactory adjustment, consisting either of a definite clearing up of the problem or of marked improvement; in 59 of the cases, the results were not satisfactory; 17 families moved, leaving no address, before the results of the nurses' efforts could be fairly evaluated; in the remaining 42 cases, failure in adjustment was usually accompanied by lack of interest on the part of either the patient or his family.

Incipient behavior problems with young children, which the nurse can help by advising with the parents of the child and adjusting home conditions and home management would seem, according to the results of our Henry Street study, to be the special province of the intelligent public health nurse, who has had some background of mental hygiene training. The nurses are urged to discriminate very carefully between the type of problem which they can help themselves, and the more serious, complicated problem which needs immediate reference to a psychiatric clinic, not only for study and diagnosis, but also for expert psychiatric treatment and follow-up. Thus far, there seems to be little tendency on the part of the nurse to retain under her own guidance the type of case which should be referred.

Glee L. Hastings, Mental Hygiene Supervisor

An Outline of Introduction to the Field

For School Nurses

By Anne Dickie Boyd
Supervisor of School Nurses, Denver, Colorado

THE previous training or experience of the individual nurse influences the type of introduction she will need. If she has had experience or field training in a general public health nursing organization she will have mastered, to a degree at least, the technique of home visiting, and she will have acquired some proficiency in the management of clinics. Assuming such background as fundamental, the following outline indicates the steps essential for the new nurse.

Study of the program and policies of the organization employing her as described in the general bulletin issued by the department, the booklet of instruction to nurses, and brief conferences with the director of the department and the supervisor of nurses.

Brief inspection of all forms used by the department and description of their use by the supervisor.

Observation of each activity as it is being carried on by other staff nurses.

Supervision of each activity as she attempts it independently, including home visits.

Reading of books on general matters pertaining to school health, and articles in health and social magazines.

The nurse without the general background of public health cannot be expected to assume the responsibilities of a district as early as the nurse with such a background, but should be allowed to observe and take notes on what she sees, and should be encouraged to do some studying as soon as possible in order to prepare her for the very specialized duties of a school nurse.

NURSES' INSTRUCTIONS

Appointments

Appointments for visiting schools should be made and kept punctually or the school notified to the contrary.

Notify the principal upon your arrival. If the principal is not in his office leave word with the secretary, and if there is no secretary leave a note on the principal's desk stating that you are in the building.

Never take children from a classroom without explaining to the teacher what you want of them. If you are to take a number of children from several rooms, inform the principal of that fact and your reason for so doing.

Visit every classroom in every school where you are permitted to do so. If the teachers are not referring cases to you, point out cases that they should have referred to you and educate them to see things which are there.

Technique of the examining room

All details of the examination should be hygienically correct.

White oilcloth should be used on the table. A towel may or may not be used over it. Waste baskets should be lined with paper bags.

The ventilation of the room should be carefully watched.

Only the parent or parents of the child being examined at the moment should be within hearing distance of the physician's voice.

Arrangement of supplies on the doctor's or nurse's table should depend upon the wishes of the individual, but neat appearance should always be considered.

Do not have the boys and girls in the examining room at the same time.

Equipment and Supplies

Bags must be kept clean; they should be cleaned weekly and supplies and equipment inspected.

One spare towel should be carried in bag.

Uniforms should be kept neat, no one whose own appearance is not neat can teach sanitation effectively.

Supplies, physical records, etc., should be returned to the central office immediately after the completion of the examination, and replaced in order.

Excessive supplies should not be taken to school.
One nurse will be assigned for clinic duty on Saturday.
If a nurse wishes to make home calls Saturday morning, she should leave the name and address of such calls with the secretary. If she wishes to take a patient to a clinic she should leave word to that effect Friday evening.
Nurses will be expected to wear uniforms if they intend to make home visits Saturday morning. If uniform is not worn on Saturday an apron should be worn over street dress.

Social Problems

Social problems should be referred to agencies equipped to handle them.
Clear all cases with Confidential Exchange before referring them to a relief agency. Register with Confidential Exchange all cases with whom you do intensive work.
Keep up to date your home visit record slips with reference to Confidential Exchange.
If a family whom you have referred to a relief agency is not receiving the attention you consider essential, discuss it with the agency instead of the family. It may help you to understand the other agency's point of view.

Control of Communicable Diseases

The instructions on control of communicable diseases given in the Outline (too detailed to print here) are in accord with the most up to date methods, permitting children who have not had chickenpox or mumps to remain in school ten days following exposure before excluding them. In the case of measles children are permitted to remain in school five days before exclusion. Diphtheria carriers who have been excluded from school are cultured once a month after their return until four negative cultures have been obtained.

The instructions stress the necessity of keeping all communicable disease records for children and classrooms up to date, including the children's record of immunity to disease. Of course all instructions for the control of communicable diseases must be in accord with local and state regulations.

SOCIAL HYGIENE EDUCATION

At the Congress of the Medical Women's International Association, held in Paris in April, the Congress formally adopted conclusions on fifteen papers from different countries at the session dealing with sex instructions for children and adolescents. In brief these conclusions are:

That sex instruction in some form should be given, though preferably not under that name.

That to very young children elementary sex instruction should be given by parents.

That during school life biological teaching concerning the facts of reproduction should be included in the routine teaching of nature study.

That parents and teachers should themselves be educated in sex matters.

That inasmuch as physiological knowledge, however wisely imparted, does not necessarily influence conduct, sex education of adolescents should be supplemented by instruction in ethics to ensure control of the instinctive impulses and their subordination to a social ideal.

That it is the doctor's special function to deal with the pathological sides of the question—namely, to give advice as to treatment and care of difficult or abnormal children, and instruction on the subject of social diseases.

Journal of Social Hygiene

THE CHRISTMAS STORY CONTEST

The inter-staff contest for the best Christmas story submitted by the nurses of the San Francisco Visiting Nurse Association, the Detroit City Department of Health, the Indiana State Nurses and the American Red Cross Public Health Nurses closed October 1 and the stories are in the hands of the judges. The prize story will be printed in our December number.

Iron and Anemia

Iron and Certain Other Minerals in Relation to Various Forms of Anemia

By Martha Koehne, Ph.D.
University of Tennessee, Knoxville, Tennessee

IRON is associated in the minds of most people with good red blood, for it is an essential constituent of red blood cells. The amount of iron in the adult human body is relatively small, being usually estimated at 0.004 per cent by weight, making a total of only three to four grams in the whole body. Sherman stated (1927) that the percentage of iron in the body at birth is about three times as great as in adult life. Since in infancy the chief food, milk, is very low in iron, we can readily see that this store of surplus iron at birth might become exhausted by the time the infant has trebled its birth weight.

About one-half the volume of the blood is made up of cells or corpuscles, the most numerous being the red blood cells of which from 86 to 94 per cent is hemoglobin. Hemoglobin normally contains 4.5 per cent hematin which in turn contains 0.2 to 0.4 per cent iron. It is the hemoglobin that carries oxygen to the cells and tissues of the body. The red cells number from 4½ to 5 million per cubic millimeter of blood. They have no nucleus when seen under the microscope and are semi-solid, elastic, yellowish cells of rather uniform size and shape. They are manufactured in the red bone marrow found in flat bones of adults and in both long and flat bones of children.

One can best appreciate the importance of iron in nutrition through studying some of the forms of anemia—their nature, cause, methods of prevention and cure. Anemias in general are characterized by either a low number of red blood cells per cubic millimeter of blood, or by variations in their size, shape, or the presence of nuclei, or by a low percentage of hemoglobin, or by combinations of these abnormalities. People with anemia are pale and have little strength or endurance.

The medical profession recognizes many different forms of anemia in persons. Some of these varieties are purely *secondary in nature* and the anemia will not improve conspicuously until the primary cause has been eliminated. The following are examples of secondary anemia:

Hemorrhagic anemia—acute or chronic. The blood loss may have been occasioned by surgical operations, accidents, hemorrhoids, ulcers in the digestive tract, fibroid tumors, tuberculosis, etc.

Hemolytic anemia—where the red blood cells are being destroyed more rapidly than they are manufactured. Certain bacteria may act as hemolytic agents, as in streptococcus infections, or the blood cells may be destroyed by certain chemical toxins—such as various coal tar products or lead salts, or the toxins may be of metabolic origin as in some toxic pregnancies.

The anemia may be secondary to another more obvious chronic disease such as cancer, especially of the stomach or the ascending colon, nephritis, sprue, pellagra—the anemia of sprue being of especial interest nutritionally.

Nutritional anemia—caused by deficiencies in iron and possibly other minerals in the diet. It is common in infants who are kept too long on an exclusive milk diet.

PRIMARY ANEMIAS

Other forms of anemia have less obvious causes—these are classed as *primary anemias. Aplastic anemia,* for which there is no known cure, is caused by an atrophy of the red bone marrow thereby preventing the manufacture of red blood cells. *Pernicious anemia* is characterized by a lowered ability of the red bone marrow to manufacture red blood cells successfully, because the

blood no longer contains a substance, which is ordinarily dissolved out of certain foods by the hydrochloric acid in the stomach. The nature of this substance is at present unknown. People who have pernicious anemia have no hydrochloric acid in the gastric juice. The red cells are few in number, very irregular in shape and size and contain nuclei.

Certain types of anemia now lend themselves to control by dietary means and some can probably be prevented with reasonable care in selection of food. Among these forms are nutritional anemia, anemia associated with pellagra or sprue and pernicious anemia. Of these nutritional anemia stands out as being conspicuously related to lack of certain minerals in the diet, notably iron. This condition will be discussed in detail, a contrast made with pernicious anemia, and a summary given of the relation of diet and iron to other forms of anemia.

IRON IN THE DIET

For many years there has been considerable difference of opinion as regards the relative value of iron as found naturally in foods and iron salts (medicinal iron taken by mouth or hypodermically) in the treatment of nutritional anemias. With the gradual improvement in the technique of handling experimental animals it has become possible to conduct carefully controlled experiments to help solve this problem. The albino rat has been used as the experimental animal and nutritional anemia has been produced in young rats by giving them whole fresh milk as the sole food. Scientists have attempted to cure this anemia by the supplementary daily feeding of fixed amounts of iron from various sources. One group used supposedly chemically pure iron salts and concluded that the ability of iron salts given by mouth to cure nutritional anemia depended first upon the solubility of the iron salt (those that were difficultly soluble were ineffective) and second on the iron being in the ferric state. The iron salts that gave the best results were ferric acetate, albuminate, chloride and citrate. Not all soluble ferric salts were effective.

The Wisconsin chemists have since proved, however, that if the above iron salts are highly purified they lose their ability to cure nutritional anemia. Do such salts frequently contain traces of an impurity that is of importance, together with the iron present, in the manufacture of hemoglobin? Further work demonstrated that the ash from each of certain foods contained traces of copper that had to be present along with iron before hemoglobin could be manufactured. The first experiment was repeated using absolutely pure ferric chloride in the same amount that had been ineffective in their own previous tests, added to it a trace of pure copper salt and the blood of the anemic rats promptly returned to normal value as regards hemoglobin.

In September, 1927, and June, 1928, these same chemists at the University of Wisconsin reported iron analyses of many food materials of plant and animal origin. They list them in the following order as regards their content of iron. The list is arranged in descending order. The foods at the beginning are richest in iron, those at the end, poorest in iron: hog liver, dry legume seeds, beef liver, deep green leafy vegetables, beef kidney, dried fruits, nuts, whole cereals, beef muscle, eggs, poultry, green peas and beans, roots and tubers, other vegetables, fish, fresh fruits, and milk. Beef juice contains only about 10 per cent of the iron present in the original meat. If the food contains a great deal of coarse bulk (as raisins and bran) or is generally very poorly masticated (as are raisins and nuts, for example) it is doubtful if the body is able to assimilate all the iron that may be present in the food.

The copper content of human foods has not yet been reported, but among stock foods, the manufactured feeds are highest, probably due to contamination with copper utensils used in their manufacture. Seeds and seed products are next most valuable sources of

copper, then hays and grasses, with straw lowest of all. It has been demonstrated that the amount of copper in milk is highest when it has been dried, evaporated, or churned in copper vessels. Milk naturally contains a very faint trace, however. Unquestionably liver, kidney, muscle meat, and greens contain copper, but there are no published analyses giving their comparative values in this respect.

PRACTICAL APPLICATION

The practical lessons we may draw from all these studies are as follows:

Begin to train children from five to six months old on to eat a variety of foods. Sieved vegetables, strained cereals, etc., may and should be given to babies during the second six months of their life and thereafter. This supplies them with iron and traces of copper and probably traces of manganese. The public *must not* be told to take copper salts. *Pure* iron salts are valueless, but soluble ferric iron salts containing traces of the necessary mineral impurities are effective, taken by mouth or as injections. Natural foods are to be preferred, however, because they contain bulk, often valuable vitamins, as well as iron and traces of copper and manganese. Direct sunshine probably aids in the assimilation by the body of these minerals as it does for lime and phosphorus. People suffering from a nutritional anemia should be given a well balanced high caloric diet containing meat or liver, green leafy vegetables, with cereals, fruit, and egg, together with the amount of milk needed for general nutritional purposes. They should be kept quiet, with plenty of fresh air and direct sunshine or cod liver oil to help in the assimilation of this food.

OTHER FORMS OF ANEMIA

With the secondary anemias in general, the same dietary treatment should be used, *after* the cause of the anemia has been corrected or eliminated. With pernicious anemia, however, a different line of treatment is necessary because it develops from quite a different course. Iron salts and traces of copper will have no effect whatever in improving the condition of a person so afflicted. Pernicious anemia bears no relation to the supply of iron, copper, or manganese in the diet. It develops when a person has been living for varying periods of time without hydrochloric acid in the gastric juice secreted by their stomachs. One of the functions of gastric juice now seems to be to help dissolve out of certain foods something—we do not know just what—that is carried by the blood to the red bone marrow. This substance in some strange manner confers upon this bone marrow the ability to properly manufacture red blood cells. When this substance has been absent from the blood for periods of time due to lack of hydrochloric acid in the stomach the bone marrow loses this power and turns into the blood incompletely formed cells and gradually the disease known as pernicious anemia develops. This same substance also seems to have something to do with the sheath that surrounds nerve fibers, for in pernicious anemia this too degenerates, leading to serious nerve disorders.

The only natural foods from which such patients can, in their own digestive tracts, extract this active substance that is so fundamental to the normal composition and function of blood cells and nerve fibers, are liver and kidney. Hydrochloric acid is not necessary in its extraction from such foods, but it is necessary before people can extract it from meat and other foods. That this substance is not iron or copper has been demonstrated by Middleton (1928) and others. The Eli Lily Company are the authorized manufacturers of an effective commercial liver extract that can be taken in place of liver. Pernicious anemia patients can be restored to normal health by the regular use of liver or liver extract but go back to their anemic condition when its use is discontinued. A generally well balanced diet is of course advised for all such people. The regular use of liver or liver extract restores the blood to its

normal condition but there is no evidence as yet that it results ultimately in the return of hydrochloric acid in the gastric juice, neither will it bring about regeneration of previously destroyed nerve fiber sheaths.

Tropical sprue seems to respond remarkably to the routine liver diet recommended for pernicious anemia. The reason is not yet apparent, however. It is a well known fact that pellagra can be prevented as well as cured if taken in time by including regularly in the diet lean fresh meat, milk, yeast, and green vegetables. As the disease disappears, the anemia associated with the disease disappears.

The Institute of American Meat Packers, 509 S. Wabash Avenue, Chicago, publish a little booklet giving 40 or more recipes and suggestions for the use of beef, pork, veal, and lamb liver. Calves' liver should be reserved for invalids in order to keep the price reasonable. More educational work needs to be done to encourage the use of other forms of liver, such as those from pork, lamb and beef.

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Spinach is now attracting the attention of the caricaturists. A New York paper celebrated the recent truckmen's strike by a delightful cartoon by Rollin Kirby. Mother remarks, "I'm sorry, Junior, but owing to the strike there is no spinach." No sorrow appears on the face of Junior.

In a drawing by Carl Rose in the New Yorker the mother says solicitously to her young daughter, "It's brocoli, dear"—the exceedingly modern young miss answering, "I say it's spinach, and I say to hell with it."

POSTER CONTEST

Watch for announcement in December of big N.O.P.H.N. Poster Contest! Open to nurses and everybody!

Report of the Institute for Social Work Executives

Held at Blue Ridge, North Carolina

By Nora Spencer Hamner, R.N.
Executive Secretary, Richmond Tuberculosis Association, Richmond, Va.

MY first impression of the Institute for Social Work Executives was that I was hopelessly lost in the midst of some seventy-five social workers, who spoke as glibly of dependency and delinquency as we speak of morbidity and mortality. They used such phrases as "case loads" and "leisure time" with as much ease as you and I use our own time-worn "nurse hours" or "home visiting." Before the end of the first day, however, I found that we spoke the same language when it came to budgets. The program was headed "The Apportioning of Funds for Social and Health Work," and it was apparent that there had been a great deal of thought and study in planning the details of the program.

PRIORITY OF NEEDS

It was the first time, to my knowledge, that a group of social work executives met together to discuss the priority of needs in the four major social fields—dependency, delinquency, recreation and health. I was impressed with the interdependence of the various social work fields and made to realize that the other groups have as great a responsibility in making any community happier and healthier as have the health workers. Misuse of leisure time causes delinquency which is frequently followed by poverty and in turn by sickness. You may transpose this statement and you will get the same result!

I was made to feel that a better understanding by the health workers of the problems of delinquency, dependency and recreation, is absolutely essential for the development of a plan which will meet the needs of the community. This applies equally to the other groups in relation to our health problems and to each other's problems.

The consideration of the apportioning of funds on the basis of the needs of the community and their relation to each other was entirely new to me and appealed to me as a sound procedure. Plans were discussed whereby we might determine these needs and arrange a program to care for them. Ways in which state and national organizations could work with their local agencies, community funds, and councils of social agencies in planning these programs and in developing public support for them, were also discussed.

I was asked to act as chairman of the committee on health problems.

The committee was asked to state what factors should be considered in determining what the health needs of the community are, the extent of these needs, the types of services needed to care for them and the order in which funds should be provided for their care.

The committees on delinquency, dependency and recreation were asked the same questions in their respective fields. The first three hours each morning were devoted to discussion of these problems by the entire group, and the fourth hour was given to round table discussions by committees. Every person attending the institute served on a committee.

STANDARDS FOR COMMUNITY CHESTS

The discussion on standards for community chests probably created the greatest interest. Those of us whose work is supported partially or wholely through a chest were deeply interested in the report rendered by the conference on the best type of organization and the functions that a chest should perform, also the qualifications that a community chest executive should possess. It would be well if every cor-

porate member of the National Organization for Public Health Nursing and other health agencies secured one of these reports, studied it, and used their influence in developing the standards provided for in the report in their local chest or council of social agencies.

Executives representing every phase of social work came from every southern state east of the Mississippi River and a few northern states. Twelve national organizations were represented. The group voted unanimously to hold a similar institute next year on a subject of interest to all types of social work executives.

I hope that it will be possible for the National Organization for Public Health Nursing to be represented at the next Institute.

STATEMENT FROM THE U. S. VETERANS' BUREAU

Editorial Note: We wish to correct and amplify the statement in regard to qualifications for public health nurses in the United States Civil Service, appearing in the article entitled "*The Public Health Nurse in the Civil Service*" in the October magazine. The statement should have read as follows:

Graduate nurses (visiting duty) and graduate nurses (junior grade) must have reached their twentieth but not their fortieth birthday.

Applicants must have graduated from a four-year high school course, or have completed 14 units of high school work—provided that those otherwise qualified, who do not meet this requirement, will be given a non-competitive mental test. (For further details write for Bulletin No. 202, unassembled.) The U. S. Veterans' Bureau requires one year of institutional or two years private duty post-graduate experience in addition to graduation from a recognized school of nursing.

In addition, the U. S. Veterans' Bureau requires (No. 202) "not less than one year's institutional or two years' private duty post-graduate experience in nursing." For Graduate Nurse (visiting duty)—". . . applicants must also establish at least four months of post-graduate training in public health or visiting nursing at a school of recognized standing, or, in lieu of such training, one year of full-time paid experience under supervision in public health or visiting nursing."

The Veterans' Bureau is the largest of the independent branches of the Federal Government, the Director being responsible to the President. It was organized originally for the care of the veterans of the World War but today extends its benefits to the needs of the veterans of all wars, giving to them medical care and treatment without regard to the nature or origin of their disabilities.

Although this service is the youngest of its kind, it has during this comparatively short period developed a centralized and highly efficient organization which has made a distinct contribution towards the raising of general standards of nursing education. Approximately 1,900 nurses are on duty in the Nursing Service. From the very beginning nurses with special training in public health nursing have been employed in relation to diagnosis, treatment and follow-up.

In order that the nurses might be better equipped to render efficiently the specialized care essential for neuropsychiatric and tuberculous patients a number of instruction courses have been arranged by the Bureau in the past. In line with this plan of working for higher standards within the service as well as without, an important step has been taken: on July 12, 1929, the Director of this Bureau approved (1) The establishment of a formal course for attendants, to better prepare them to render more intelligent and acceptable service to the patients of the Bureau. (2) A formal program of staff education in Psychiatric Nursing to be initiated in all the hospitals of the U. S. Veterans' Bureau—special postgraduate courses to be made available for the nurses in the service.

Further information may be obtained from Mary A. Hickey, Superintendent of Nurses, United States Veterans' Bureau, Washington, D. C.

The Savannah Health Center

An Account of an Amalgamated Public Health Nursing Service *

By Helen E. Bond
Director, Savannah Health Center, Savannah, Ga.

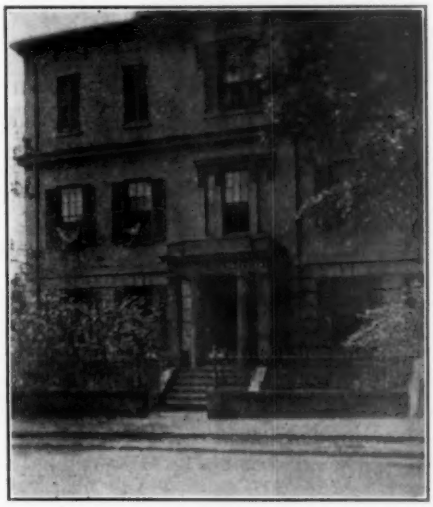
THE keynote of the organization and the secret of its accomplishment is "coöperation," meaning pooled resources and effort and a fine spirit of service on the part of the officers and lay members of the Health Center.

The amalgamation of public and private health agencies in Savannah, Ga., now known as the Savannah Health Center, started nine years ago with an agreement between the Mary Maclean Visiting Nurses' Association and the Junior League, which conducted free clinics, to employ a joint director and operate under one control. The Louisa Porter Home Board generously came into this amalgamation and supplied the headquarters free of charge to the Health Center, both for clinics and offices. The Colored Federation of Women's Clubs joined the amalgamation, paying for a colored nurse to work in the colored clinics. The Medical Society coöperated by giving free medical service at clinics in addition to the service already given by city health officers. So the Savannah Health Center was instituted, largely through the efforts of public spirited men and women, including the present mayor of Savannah.

Five years later it was decided to try to effect an amalgamation between the Health Center and the City Public Health Nursing Service, thus doing away with a good deal of duplication in general field work in the districts. The Health Center nursing service was also handling nursing work for the Metropolitan Life Insurance Company policyholders which added another opportunity for duplication.

UNDER ONE DIRECTOR

In October, 1925, a committee drew up a tentative agreement by which all the public health service at Savannah except the specialized tuberculosis work was to be put under one control with Miss Ann Hellner, who was at that time supervisor of the city nurses, as director of the amalgamation. This amalgamation was to be known as The Savannah Health Center and was approved by the city authorities and the various organizations interested and has been in effect ever since.



The organizations which are contributing financially to the Health Center and a part of the whole of whose work is supervised through the Health Center are as follows:

The City Health Department, the Mary Maclean Milk Depot and Visiting Nursing Association, the Junior League, the Rotary Club, the County Commissioners, the Georgia E. Thompson Chapter of King's Daughters, and the Colored Federation of Women's Clubs. The Louisa Porter Home Board gives offices and clinic rooms rent free.

Other member organizations coöperating closely are:

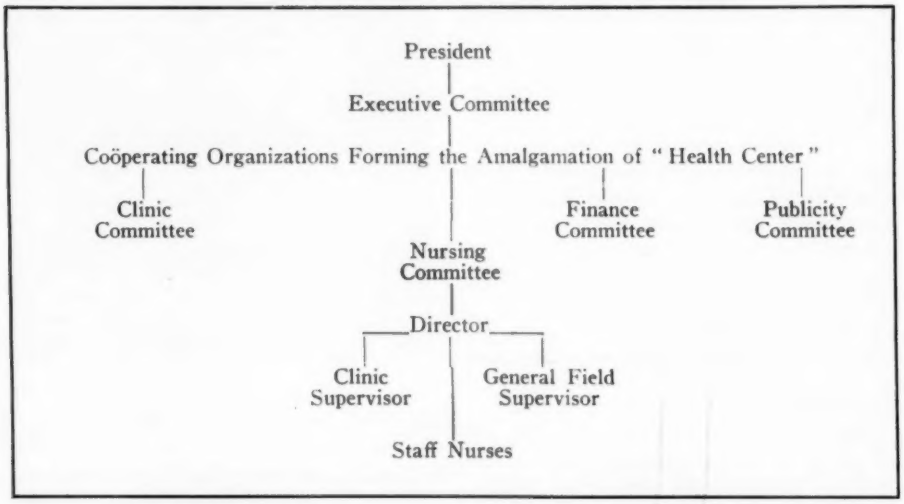
* A continuation of the first description of Savannah's amalgamated service which appeared in The Public Health Nurse, November, 1927.

The Froebel Circle of King's Daughters, Council of Jewish Women, Chatham-Savannah Tuberculosis Association, Savannah Family Welfare and County-City Board of Education.

These with other affiliated organizations have a total membership of approximately 6,716.

The administration of the Health Center is controlled by the president and his executive board and also the amalgamated organization known as the Health Center. This is made up of organizations which are an integral part of the amalgamation. Each member organization may have three votes at any meeting of the Health Center. There are various standing committees, the most important from an administrative point of view being the nursing committee.

ORGANIZATION OF THE SAVANNAH HEALTH CENTER



SERVICES OFFERED

The services offered at present are: general bedside care and instructive visits to all types of cases; health supervision of well babies and preschool children; service at 35 clinics per week; supervision of midwives; kindergarten health inspection and school nursing. The educational program includes prenatal classes, well baby conferences, midwife classes, staff nurses' conferences, a definite publicity program, circulating library of professional books and magazines, and attendance and participation at state and local professional meetings by the staff.

In 1928, 52,673 home visits were made and 19,847 patients visited clinics.

The school nursing service was initiated October 1, 1928, with a staff of seven nurses (4 white and 3 colored) doing specialized work. An introductory program was carried out for the first two weeks, followed by the regular routine school nursing program.

A description of the maternity program will appear in our December number.

The total staff of the Health Center consist of 31 nurses (17 white and 14 colored), 2 supervisors, and the director (34 in all), one charge clerk and two stenographers.

A loan scholarship fund of $1,000.00 for post-graduate work was established by one of the member organizations, The Mary Maclean Association, and is in use by a staff nurse. It is planned to arrange for two scholarships for post-graduate work for colored nurses through the Julius Rosenwald Fund.

The Tuberculosis Association, which

coöperates closely but does not work directly through the Health Center, conducts the free clinics for the tuberculosis patients, makes the home visits to patients and contacts, and conducts a fresh air unit for incipient cases. If nursing care is needed for any patient with tuberculosis, the case is turned over to the Health Center until bedside care is no longer needed.

SPECIAL HEALTH PROBLEMS

Savannah has its special health problems. Some of the chief ones are:

Special disease, endemic: hookworm, malaria, pellagra, and Brill's disease. Many infectious diseases, such as smallpox and typhoid, are brought in from the outside as Savannah is on the coastal highway and also is a seaport town. Also the tetanus baccili seem specially numerous and virulent in this region.

Perhaps the greatest problems are caused by the large proportion of colored population, which is 47 per cent of the total population (1928). This means for the colored population, low standards of living, high infant death rate, low moral standards along certain lines, also a very high percentage of illiteracy. Inevitably this affects standards of the total population.

Other problems more or less affecting the health status are: the need for further development in schools, the great amount of unemployment at the present time and business depression.

FINANCIAL SUPPORT

The financial support of the Health Center is a remarkable example of what may be done with pooled effort and interest. The accompanying chart explains the sources of support. The Community Chest contributes to many of the membership organizations but does not contribute directly to the Health Center. Each membership organization supplies some definite contribution to the whole—it may be the total salary or part salary of a nurse, a car, clinic rooms, dental service, or other expense.

Organizations contributing to the financial support of the Health Center:

City Department of Health
Mary Maclean Association
Junior League
County Commissioners
Louisa Porter Home Board
Community Chest
Colored Federation of Woman's Clubs

Some mention must also be made of the splendid volunteer work of member organizations. Through the generosity of the Rotary Club a very fine

The Nursing Staff

camera was given to the Health Center and a special lighting system for taking pictures installed in the Junior League Clinic rooms. This added much to the work of the orthopedic clinics, making possible a better record of unusual cases.

Other forms of volunteer service given in 1928 and continued in the present program include:

Clerical work in clinics by Junior League, 1,710 hours.
Motor car service by Mary Maclean Association, 468 hours.
Motor car service given by Junior League, 624 hours.
Obstetrical packs, layettes and cord dressings and ties made and given by Georgia E. Thompson Chapter of King's Daughters.
Equipment and supplies for orthopedic patients given by Rotary Club and Scottish Rite Masons.
Free service given by physicians in all clinics, except the dental, venereal disease and colored prenatal clinics.

HOW IT ACTUALLY WORKS

The program will perhaps be more vividly demonstrated if we follow a typical case:

Mary Brown, a young white woman, became pregnant. She felt "po'ly" in local parlance. The midwife she engaged reported the case to the Health Center and a nurse called regularly to give health supervision and prenatal instruction. Both the nurse and the midwife advised Mary to visit the prenatal clinic. She did so and the routine Wassermann blood test showed a positive reaction. Mary, encouraged by the nurse and the midwife, attended the clinics regularly for free treatment and examination and also the prenatal classes. She had followed the directions of the nurse and midwife and was well prepared for her delivery, which was normal and conducted by the midwife. The midwife gave general care daily and the nurse came in every three days to inspect the cord and eyes of little Vanta, take temperatures and give general health supervision. On the 10th day the nurse demonstrated to the mother a "proper baby's bath" and in a few days returned to have her pupil demonstrate the bath to her. The nurse visited the young mother and baby regularly. At the end of six weeks Mary had a post-partum examination and brought little Vanta to the Baby Station regularly to get weighed and measured and to receive further instruction.

When Vanta was 8 months old she began to lose color and weight and was not "doin' well." Her mother promptly took her to the Free Health Center Pediatric Clinic for treatment and advice and Vanta soon attained "normal" again. When at 6 years Vanta's teeth showed small cavities she received treatment at very small cost at the Health Center dental clinic. As Vanta's father was not making an adequate living wage, her mother was allowed to buy milk through the Health Center Milk Depot at $0.08 per quart (regular price $0.18 per quart).

When Vanta entered school she had already had a successful smallpox vaccination and been immunized against diphtheria, had dental defects corrected and was under dental supervision. Best of all she had formed good health habits, largely due to the Health Center service.

During her first school year Vanta received a very thorough health examination, and on the advice of the physician and school nurse Vanta's tonsils and adenoids were removed through the free "T. & A." operations arranged for at the Health Center. The following summer the nurse arranged to have the child spend 4 weeks at the seashore "Fresh Air" home where she grew plump and rosy. So little Vanta started on the arduous but interesting path of life, helped on the way by the Health Center. The Health Service cycle will be complete in the future when there is another, perhaps even "bigger and better," little "Vanta II."*

* *Editorial Note:* The remarkable feature of Vanta's cycle of life is that from conception to the grave she will be under the care of one staff of public health nurses—unless she contracts tuberculosis—and that all her health records are on file in one office!

William Lyon Phelps in *As I Like It—Scribners* for September—remarks: "I am an ardent admirer of the General Practitioner, especially those of the country variety. Here is a poem on the subject . . ."

IF

If you can change tires at four below at four A.M.,
If you can set a fractured femur with a piece of string and a flat iron and get as good results as the mechanical engineering staff of a City Hospital at 10 per cent of their fee;
If you can drive through ten miles of mud to ease the little child of a deadbeat——
If you can do a podalic version on the kitchen table of a farmhouse with husband holding legs and grandma giving chloroform——
If you can diagnose tonsillitis from diphtheria with a laboratory forty-eight hours away,
If you can pull the three-pronged fish-hooked molar of the 250 lb. hired man——
If you can maintain your equilibrium when the lordly Specialist sneeringly refers to the General Practitioner——
Then you *are* a real
Country Doctor!

The Nurse in Industry *

By Violet H. Hodgson, R.N.
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INDUSTRIAL health is an integral part of the community health program. It is not something apart or complete in itself. As the economic and social aspects of community life are intimately related to the status of industry, so, too, is the whole picture of community health affected by the standard of health in the industrial group. In like manner a high degree of health among the wage-earners increases the possibilities for maintaining a standard of living in the home favorable to the practice of the laws of hygiene and healthy living. A community health program that is successful in reducing the incidence of disease in the infant, preschool and school groups insures the worker a certain amount of freedom from the mental, physical and economic strain attendant upon sickness in his family, which, in turn, is reflected in the quality and quantity of his production in the plant. Thus we see not only an interrelationship but an interdependence between the health program within and without industry.

No one service in the plant has a greater opportunity for effecting this correlation than that offered by the nurse. As a public health worker she brings to industry a knowledge of community resources that enables her to adapt the industrial health program most effectively to the larger program in the community. No better example of the need of a close tie-up between the two programs can be found than in the control of communicable disease. Interpretation of the sanitary code and an explanation of the preventive measures advocated by the local health officer in the control of typhoid, diphtheria, and smallpox will go far in securing the intelligent coöperation of the employee and his family in reducing the incidence of these diseases in the plant and in the home. Providing greater continuity to the health service in industry and in the community is the privilege of the nurse.

The Health Program in Industry

Health, like all knowledge, whether of abstract subjects acquired in school, of community and home relationships through contact with other individuals, or of processes within the plant, is the result of education and practice. Education in methods of accident and sickness prevention, assistance in the correction of defects that decrease the individual's capacity for production, and guidance in ways and means of health enhancement are sound procedures in any health service, and if wisely and efficiently administered will be reflected in greater production in the plant and a larger measure of success in the attainment of satisfactory home and community relationships. It is in such a program that the nurse can be of greatest service to industry.

Nursing, salesmanship and teaching are the mediums through which she makes her contribution to such a program. How much more far-reaching will be the effects on the entire community health program if the employee is being educated in matters of health at the same time that his children are receiving similar instruction in the public schools.

A shift in emphasis is daily more apparent in the field of nursing. Increasingly the community is looking to the nurse for interpretation of the laws of prevention as well as the application of nursing skills in the alle-

* From an address delivered at the Eighteenth Annual Safety Congress, Chicago, Ill., October 1, 1929.

viation of disease. What are some of the avenues by which the nurse can render most valuable service to this program?

THE MEDICAL SERVICE

Some measure of medical supervision is prerequisite for the establishment of a nursing service in industry. One of the chief functions of the nurse is to supplement the services of the plant physician in the care of the sick and injured and interpret his precepts in the program of disease prevention and health preservation, to the employee. Without the physician, her activities are limited to those which may be assignable to a nonprofessional group such as we frequently see so ably carried out by employees trained in first aid work. As a nurse, she is ethically and legally guided in the practice of her profession by certain fundamental principles. In the practice of her nursing skills the treatment must be prescribed by the physician. The following duties of the industrial physician as outlined in the "Preliminary Survey of Physical Examinations for Employees in Industry" will assist in determining the function of the nurse as related to that of the physician.

1. "Emergency care for industrial injuries or possibly more extended treatment for ambulatory cases."

First aid care of the sick and injured is undoubtedly the most generally accepted service of the nurse in industry. It is in this field that results are most accurately measurable in the reduction of lost hours and a decrease in the benefits payable from compensation insurance. The follow-up care of minor dressings under the physician's direction conserves his time for the administration of more technical and important features of his program.

As a teacher and saleswoman, there is no more ideal time to put over her message of prevention to the employee than during the period when she practices her nursing techniques in dressing a wound. It is the psychological moment to gain the employee's attention to a matter which is concrete and very real to him. The theory of germ infection will seem amazingly simple if explained at this time when the connection between the wound and the invasion of bacteria can be made a logical possibility. Surgical asepsis practiced by the nurse at this time can be intimately associated in the mind of the employee not only with the prevention of infection of his wound, but with the prevention of disease through proper washing of the hands before handling food. Emphasis on the use of safety appliances will engender a greater respect for their value to the employee's welfare. By firmly establishing the confidence of the employee in the ability of the nurse and her interest in his behalf, at a time of need, he will seek her advice and assistance on other problems which interfere with his efficiency and production.

2. "Examination of applicants for employment or employees transferred within the plant."

Here again is an opportunity to render a three-fold service—to the physician, the employer and the employee. In all her contacts the nurse must first be able to gain the confidence of these three before she can expect a large demand for her services. The physician who is assured of her professional ability will be glad to delegate to her certain routines in history taking. He will also be assured that the examination can proceed with the whole-hearted coöperation and understanding of the applicant as to its purpose because of the contact already made by the nurse.

She can be relied upon to assist him in securing the correction of remediable defects by the employment of sound principles of education, which sometimes require much time and patient effort thoroughly to convince the employee of the need and to secure his intelligent coöperation in their correction. To the employer all this spells efficiency, production, and better plant morale.

3. "Consideration of problems of plant hygiene and sanitation."

As the agent of the physician in this service, she functions almost exclusively as a teacher. Habits of life-long standing are not changed immediately through the introduction of modern practices of industrial hygiene and sanitation. The employee who is accustomed to sleeping with his windows closed, whose habits in the home are slovenly, who has had very little training in respecting the health and comfort of his fellowman, will not instantly welcome nor understand the need of proper ventilation, heat regulation, anti-spitting orders and the like in the plant. Patient teaching that will bring understanding and coöperation is required. Who, other than the nurse, should be better qualified to render this assistance to the physician?

4. "Periodic observation of workers known to be substandard."

Assistance to the employee in carrying out the recommendations of the physician is frequently the greatest service she can render in securing desired results. Advice, accompanied by encouragement, adds reality to the nurse's interest in the health of the employee and many times stimulates him to more earnest effort in attaining a higher physical standard.

5. "Education of workers in matters pertaining to health."

Her greatest contribution to this service is through the inculcation of habits of healthy living in the daily life of the worker. She must understand the principles of personal, plant and community hygiene and be able to impart this knowledge in an attractive manner to him so that he will apply them to the daily life in the plant and the home.

The employee will have a much better understanding of the motive of the employer in providing a plant lunchroom, where a well balanced diet under hygienic conditions is served, if the nurse has explained to him the function of the various foods in restoring and rebuilding the worn parts in his body machine. Nor will such knowledge be applied only in the plant. The father who understands the importance of green vegetables in the diet will cooperate more readily in providing them for his anaemic child at home.

Plant facilities for washing the hands before eating provide the basis of establishing a habit which, if the motive is understood and the practice is carried over into the home, will make a real contribution to the reduction of communicable diseases.

6. "Guidance of workers in securing necessary medical service, both diagnostic and remedial."

Much time and patience is sometimes required in securing the cooperation of the patient in obtaining necessary medical service outside the plant. In rendering this service to the employee, it is essential that the nurse have a clear understanding of proper ethical relationships, in order to assist the physician in industry in maintaining amicable and coöperative relations with other physicians in the community. A careful observance of ethical principles will help tremendously in producing a feeling of goodwill, an attitude fundamental to any successful community service.

THE SAFETY PROGRAM

The safety engineer has undoubtedly contributed more to the reduction of accidents and industrial hazards than any other one factor in plant management. Though the nursing service may not be as directly related to this department as to medical service, the nurse has many opportunities for making a definite contribution if she is as thoroughly familiar with its program, methods and objectives as the safety engineer expects other plant employees to be. An intelligent understanding of the various manufacturing processes, plant housekeeping, and safety devices employed in accident prevention will enable her to give a more concise and helpful report on first aid cases which she is obliged to handle in the absence of the physician. The value of such a report to the physician and employer

in handling compensation cases need not be enlarged upon. The results of her advice to the injured employee and to all employees, as opportunity offers itself, on the practice of safety and the use of safety appliances, should contribute much to obtaining their cooperation in the safety program.

THE INDUSTRIAL RELATIONS PROGRAM

The nature of the employee's reaction to his fellow workman, the boss, and his employer depends so much on his physical condition and his mental attitude that whatever service the nurse can render, through an intelligent understanding of the problem of the employee and the motives and desires of management, to improve his physical and mental health will be reflected in the desired goal of the industrial relations department so ably defined by Bruère and Pugh: "The modern art of industrial relations is the act of courteous, coöperative accommodation of interests between employers and employees with a view to the successful operation of the business in which they are concerned."

These are but a few of the many ways in which the nurse can be an efficient and highly productive employee in the health program of industry and the community. The fundamental principles which guide her in this work are not unlike those of other branches of public health nursing. The difference lies in the application of these principles to the needs of each individual plant and industry.

PREPARATION OF THE NURSE FOR SERVICE IN INDUSTRY

Public health nursing in industry is a far cry from the kind of service the nurse was prepared to give during her period of training in the hospital. In industry the nurse encounters quite a different situation—hers is the job of adaptation to a new environment. She must correlate her nursing service with the many aspects of industry and its health program. She is expected to function equally effectively as a teacher of the fundamental principles of disease and accident prevention and health promotion, as well as to administer nursing care to the sick and injured. Industry needs master mechanics for the supervision of the plant machinery; so, too, it needs masters in the art of administering to the needs of the human machine. What, therefore, are the outstanding qualifications that will enable the nurse to render satisfactory service to industry in this capacity?

Graduation from a recognized school of nursing and state registration are the basic requirements for any branch of professional nursing service. Further preparation in the principles and practice of public health nursing are important assets in equipping the industrial nurse to develop the preventive and health promotion aspects of her work. Knowledge of the principles of plant organization, personnel administration and industrial hygiene would seem indispensable in adapting her service wisely and effectively to the needs of the plant. Some executive ability will insure a more effective and business-like administration of the service. More than all this—to make her service dynamic, she must possess a full measure of those more abstract qualifications which assure the wholehearted coöperation of the employee and which elevate an otherwise mechanical service to an art in human relations. Courtesy, tact, sympathy with understanding, interest, judgment, diplomacy, a sense of fairness—all of which can be summed up in one word, personality — are the driving forces which make her services vital and personal to the human machine.

THE FUTURE OF THIS BRANCH OF PUBLIC HEALTH NURSING

What provision is being made to make this service available to plants employing 250, or, less wage earners whose combined employment is slightly less than 50 per cent of the total? What are the administrative problems involved in such a service? What of the 99 per cent of small plants with in-

adequate medical departments? What are the criteria of a productive nursing service? Are we unanimous in our interpretation of the place of the nursing service in the administrative set-up of the plant? What, if any, further part can she take in the health program which is so closely related to the larger service of industrial relations? How can we best provide industry with masters in this art of administering to the needs of the human machine? What provision should be made for supervisory and consultation service? What are the most desirable methods of correlating the health program of industry with the community program? Have the nursing records received sufficient study to determine what is essential and what is nonessential information? Are the records sufficiently standardized to lend themselves to statistical analysis? Are they of value in appraising the health service in industry?

These and many other problems present themselves for further study in the development of this field. That such a study is indicated and timely cannot be questioned, if we expect the nursing service to keep pace with the rapid strides that are being made in the field of industrial medicine and community hygiene.

The consideration of these questions should be of vital interest to and receive the united attention of plant executives, industrial physicians, community health administrators, and public health nurses in order to insure development along lines that will facilitate the correlation of this service most effectively with the plant and community health program.

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FROST

He came in silver buckles,
On a crisp, windless night;
With lace upon his bosom,
And a wig of gleaming white.

There fell upon the aster
A sudden breath of steel;
There flashed across the clover
An iridescent heel.

The most immaculate pirate,
And the stillest buccaneer,
With cool, efficient fingers
Unsheathed a jeweled spear.

Affluent heirs of April
And summer's tall trustees,
Bedazzled by his manners
Gave up their legacies.

With scarlet trail behind him
Upon a ravished land,
Fastidious, he departed
No spot upon his hand.

Anne Blackwell Payne, The Commonweal

An Experiment With the 4A Audiometer

MARY E. CHAYER, R.N.

THE 4A audiometer is a phonographic device for group testing of hearing. The phonograph is equipped with ordinary disc records, upon which are recorded several series of numbers. Attached to the phonograph by means of a telephone coil and "plug" is a tray containing eight single earphones with head wires to hold the earphone in place. To this tray may be attached additional trays, one phonograph being strong enough for five trays. If all trays are used forty people may be tested at the same time.

Students to be tested are seated preferably on either side of long tables, though school desks may be used with careful planning and some loss of time. Students are instructed to adjust the earphone first to the right ear. The operator gives careful directions to the group, after which the phonograph is started. A woman's voice is heard repeating numbers slowly, as 54—63—85—14—41—. The voice decreases in volume with each succeeding number until it fades away. The voice vibrations are scientifically measured and they decrease three sensation units with each number. The student records these numbers on a sheet provided for the purpose. After repeating a series of ten numbers of two digits each, the voice pauses briefly, and again resumes with another set of numbers, again decreasing in volume. Next a man's voice repeats the process with still another set of numbers. After four columns of numbers have been repeated the test for the right ear is completed. The earphones are now removed, the students rest for a time, the phone is adjusted to the left ear and the test is resumed with again a different set of numbers.

The purpose of the test is to discover incipient cases of impaired hearing long before they might otherwise be apparent. The administration of the test may seem to be a very simple mechanical procedure. On the contrary, judgment, precision and experience are required for uniform results.

GRADE PLACEMENT

In order to discover hearing defects as early as possible it follows that children should be tested as soon as they are able to master the technique of writing numbers while they are listening for others. After lengthy experimentation it was found that about 7 per cent of children tested in the fourth, fifth and sixth grades showed some degree of defective hearing, while 11 per cent of the third graders recorded some impairment. It was felt then that the test was not reliable as a group test below the fourth grade. Selected groups of third graders might be tested advantageously, but a greater degree of error would result and a finer discrimination in interpretation would be required.

In the present experiment the audiometer was used in 51 schools and over 10,000 students were tested. About 400 may be tested in a school day.

To obtain what we thought were accurate results it was found advisable to retest all children who failed to make a normal test on the first trial. This was done on the same day as the first test. This eliminated over 50 per cent of those who failed on the first test. In order to eliminate those cases of temporary deafness which might occur as a result of colds or other conditions, we retested again at least a month after the second test. This eliminated another large group.

It was found that any undue excitement such as a school play or carnival near the time of giving the tests resulted in poor ratings. It is interesting to note that the children seemed to be giving as close attention to the test at this time as at any other time, yet the results were poor in several instances.

The following results were obtained after the various elimination tests:

	No. Tested	No. Defects	Per cent Defects
Elementary School	5,936	414	6.9
Junior High	4,453	192	4.5
Total	10,389	606	5.7

INTERPRETATION OF RESULTS

Our interpretation of results was based on our knowledge obtained in testing added to consultations with those of the medical profession who are engaged in the practice of otology. We have made three arbitrary groupings, according to the degree of impairment which was recorded:

Group A. Those having a loss of 24 or more sensation units in either ear. Eligible for lip-reading classes. These should be referred to otologist for further examination. Should be examined yearly by otologist to guard against further loss of hearing and until placed in lip-reading classes should be seated advantageously in the classroom.

Group B. Those with loss of 15 to 24 sensation units in either ear. Should be referred to otologist for examination yearly. Should not be placed in lip-reading classes except on written advice of otologist. Should be given front seats.

Group C. Children with loss of 9 to 15 sensation units. Notify parents and teachers that these children may have slightly defective hearing and should be closely watched by teachers and parents. Should be retested yearly at school with the audiometer and any progress in impairment reported at once.

Children with obviously advanced degree of impairment of over 30 sensation units cannot be tested with the 4A audiometer. They should be referred to an otologist and a careful examination made each year.

There was found to be a high degree of correlation between the results of the test and the teacher's estimate of hearing defects among children in groups A and B, but little correlation in group C. In other words the majority of children in group C were not suspected of having defective hearing. In a few instances inattentive children who were thought to have some impairment were able to pass a satisfactory test.

As a result of our experience in the present experiment, we are planning to test yearly:

1. All fourth and seventh grades.
2. All new entrants since the last test.
3. All who have had communicable diseases since the previous test.
4. All who were found defective at the first test.
5. All children suspected of having poor hearing.

SOLVING THE MYSTERY OF THE UVULA

Punch has recently provided the world with a dissertation on the Uvula. "It seems so eager, so anxious to please, so, somehow *frustrated*. But what is its place and purpose in the scheme of things? The Oxford Dictionary apparently gives little help—or any other printed source of information." This minor but intriguing problem preyed upon the writer's mind on the lonely moors where he happened to be staying.

"One day I met a hospital nurse gathering wild thyme and bogrose in Melchett Bottom. I went to her and said to her simply, looking into her honest blue eyes: 'Tell me, Nurse, what is the Uvula for?' 'I have always wondered,' she answered frankly, 'I have sometimes thought it might be meant to keep the tonsils apart.'"

ACTIVITIES *of the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

Edited by KATHARINE TUCKER

ALEXANDER M. WHITE

Died September 21, 1929

It would be impossible to put into words the grief and sense of loss that has come to us all on hearing the news of Mr. Alexander M. White's death. Since 1920, when Mr. White first took an active interest in our organization, he has been not only one of our most valued advisers, but the most faithful, generous and tolerant of friends. He came to our aid at a point in our fortunes of extreme urgency and his vigorous, patient, and understanding help at that moment can never be forgotten. It has been one of our great satisfactions that we were able to retain his interest in a life full of so many other demands. Our Board and membership have lost a beloved friend.

FIELD TRIPS AND MORE FIELD TRIPS!

During October five members of the staff were in the field:

Miss Tucker attended the A.P.H.A. meetings in Minneapolis, combining this with N.O.P.H.N. Education Committee meetings, visited St. Paul, Minnesota, Madison and Milwaukee, spoke at the Illinois State Meeting at Moline, at the Rhode Island State Meeting in Providence, the New York State Meeting in Buffalo, and the Pennsylvania State Meeting at York.

Miss Stimson attended the A.P.H.A. meetings in Minneapolis and surveyed the Public Health Nursing courses at the University of Minnesota, Washington University, St. Louis, Mo., the University of Michigan, Ann Arbor, Mich., and Western Reserve University, Cleveland, Ohio.

Mrs. Hodgson has continued her survey of industrial nursing in certain representative industries in Buffalo, Dayton, Cincinnati, Pittsburgh, Williamsport, Pa., and Chicago. She also attended the meeting of the Industrial Nursing Section of the N.O.P.H.N. held at the time of the National Safety Congress in Chicago and presented a paper on industrial nursing at one of the regular sessions of the Congress (published in this number). A study of the Northern Westchester District Nursing Association was carried on by Mrs. Hodgson at the request of that association.

Miss Davis had a conference with Mrs. Cross, Chairman of the Board and Committee Members' Section, and Miss Peabody in Boston to plan for the year's program, and visited Brockton, New Haven, and Providence. She also attended the Board Members' Institute held at the time of the state annual meeting in York, Pa., and spoke on the assistance which a secretary can render to Board Members, at the Federation of Northern New Jersey Visiting Nurse Associations.

Miss Tattershall presented a paper on *Public Health Nursing Statistics* at the Vital Statistics Session at the A.P.H.A. meeting, and gave advisory service on records in Nashville, Tenn., and Minneapolis. She visited Dayton, Cleveland, and Detroit, and attended a meeting of the Joint Handbook Committee at the University of Chicago.

The report of the September meeting of the N.O.P.H.N. Executive Committee will appear in December.

PERTINENT FACTS RELATIVE TO SALARIES OF PUBLIC HEALTH NURSES

By Louise M. Tattershall

(Continued from the August and September numbers)

FINDINGS AS TO POLICIES AND STANDARDS FOR FIELD NURSES

Very few agencies have formulated policies in regard to training and experience necessary for the position of supervisor or director, nor have definite salary scales been adopted for these positions, so this part of the discussion refers to field nurses only. However, the policies and standards set up by agencies for field nurses reflect what may be expected of policies and standards relating to other members of the staff. Those established by health departments, boards of education, and public health nursing associations for field nurses are given in the following discussion.

TABLE 1. REQUIREMENT FOR APPOINTMENT AS FIELD NURSE TO NURSING STAFFS UNDER HEALTH DEPARTMENTS, BOARDS OF EDUCATION, AND PUBLIC HEALTH NURSING ASSOCIATIONS

	Number of agencies reporting		
	Health Depts.	Boards of Education	P.H.N. Ass'ns
General Education			
Total	31	73	85
2 years College	..	1	..
4 years High School	23	69	74
2 years High School	3	1	7
1 year High School	2	1	4
Grammar School	3	1	..
General Nursing Preparation			
Total	70	95	97
Graduate of accredited school and state registration	31	..	32
N.O.P.H.N. standards and state registration	1	..	11
State registration	14	51	18
Graduate of accredited school	21	7	30
N.O.P.H.N. standards	3	..	6
Graduate nurse	..	37	..
Public Health Nursing Preparation			
Total	75	76	98
None	51	44	79
Theory and practice	4	8	7
Theory or practice	5	2	6
Theory only	5	12	3
Practice only	5	10	3

It is extremely interesting to note the large percentage of agencies—74 per cent of the health departments, 96 per cent of the boards of education, 87 per cent of the public health nursing associations—which require 4 years of high school for appointment to their nursing staffs.

All of the agencies require graduation from a school of nursing for appointment to their nursing staffs, with state registration as an additional requirement by more than half of all the 3 different types of agencies reporting.

The fact that 68 per cent of the health departments, 58 per cent of the boards of education, and 80 per cent of the public health nursing associations, do not require any previous training or experience in public health nursing is significant, as it means that these agencies must be prepared to give the fundamentals and technique of public health nursing to new nurses coming on their staffs.

SALARY POLICIES

The beginning yearly or monthly salaries listed in the table following refer to the minimum salaries paid and do not represent the salaries that might be paid, if an exception is made, to a nurse with training or experience in public health nursing.

TABLE 2. BEGINNING SALARY PAID TO FIELD NURSES

Beginning salary Basis of		Number of agencies reporting		
Year	Month	Health Depts.	Boards of Education	P.H.N. Ass'ns
Total		49	74	92
$1920	$160	1	..	..
1800	150	2	3	2
1700–$1799	141.66–$148.33	1	1	1
1600– 1699	133.33– 140.00	5	3	2
1500– 1599	125.00– 132.50	15	10	18
1400– 1599	116.67– 123.33	3	4	9
1300– 1399	108.33– 115.00	14	9	29
1200– 1299	100.00– 107.50	7	29	30
1100– 1199	91.67– 99.67	1	8	1
1000– 1099	83.33– 91.00	..	7	..

Five of the eight agencies paying a beginning salary of $150 a month or $1,800 a year state they require training or experience in public health nursing for appointment.

Requirement

Health departments

Course in public health nursing recognized by New York State.
Eight months' course in public health nursing or 2 years' experience with 6 weeks' or 4 months' course in public health nursing

Boards of education

Two years of college and some practical experience in public health nursing

Public health nursing associations

Course in public health nursing or 1 year of practical experience—2 agencies

One health department and one board of education state no training or experience in public health nursing is required for appointment at this salary. The remaining board of health gives no information as to requirement.

TABLE 3. POLICY OF AGENCIES AS TO THE BEGINNING SALARY PAID FIELD NURSES IN RELATION TO PREVIOUS TRAINING AND EXPERIENCE

Policy	Number of agencies reporting		
	Health Depts.	Boards of Education	P.H.N. Ass'ns
Total	75	95	96
Beginning salary same, irrespective of training and experience	67	54	42
Beginning salary varies with training and experience	8	41	54

Public health nursing associations more than either health departments or boards of education tend to pay a higher beginning salary to new nurses having had training or experience in public health nursing. The general policy of health departments is to pay all new nurses the same beginning salary, 89 per cent of the departments reporting having this policy.

TABLE 4. MAXIMUM SALARY PAID TO FIELD NURSES BY HEALTH DEPARTMENTS, BOARDS OF EDUCATION, AND PUBLIC HEALTH NURSING ASSOCIATIONS

Maximum salary Basis of		Number of agencies reporting		
Year	Month	Health Depts.	Boards of Education	P.H.N. Ass'ns
Total		37	61	85
$2500	$208.33	..	3	..
2400	200.00	..	2	..
2100	175.00	1	4	2
2000–$2099	166.67–$173.33	2	8	..
1900– 1999	158.33– 165.00	3	4	8
1800– 1899	150.00– 157.50	10	10	16
1700– 1799	141.66– 148.33	..	8	6
1600– 1699	133.33– 140.00	9	3	30
1500– 1599	125.00– 132.50	10	12	23
1400– 1499	116.67– 123.33	1	3	2
1300– 1399	108.33– 115.00	2	3	3
1200– 1299	100.00– 107.50	..	1	..

TABLE 5. NUMBER OF YEARS OF SERVICE BEFORE MAXIMUM SALARY IS RECEIVED BY FIELD NURSES

Number of years of service to receive maximum salary	Number of agencies reporting		
	Health Depts.	Boards of Education	P.H.N. Ass'ns
Total	52	67	93
1	6	2	11
2	7	6	23
3	3	6	7
4	5	5	9
5	5	9	6
6	3	7	..
7	..	3	2
8	..	6	1
9	..	2	2
10	..	6	..
Number of years not defined	23	15	32

The fact that the policies of boards of education regarding the salaries paid nurses are determined by the general policies of these boards probably accounts for the small percentage of boards which have not defined the length of service necessary to receive the maximum salary and the spread of years necessary to serve.

TABLE 6. POLICY OF AGENCIES AS TO GRANTING INCREASES OF SALARY TO FIELD NURSES

Policy as to granting increases of salary	Number of agencies reporting		
	Health Depts.	Boards of Education	P.H.N. Ass'ns
Total	75	90	95
Increases given automatically	34	69	75
Increases not given automatically	41	21	20

In considering the number of agencies which report that increases are given automatically, it is well to keep in mind the statement made by many agencies that only such nurses whose work is satisfactory are kept on the nursing staff, and all nurses that are retained automatically receive an increase in salary at definite intervals. Where increases are not given automatically, they are given on the basis of merit as shown by satisfactory work.

Summing up from these findings: A field nurse who may be appointed to the nursing staffs under health departments, boards of education, and public health nursing associations, is one that has had 4 years of high school, graduate

of nurses' training school and registered in the state where she is employed. She will have had no training or experience in public health nursing. The salary she may expect to receive when she begins and the maximum salary to be received and length of time she must work to get this salary in the 3 different agencies, is as follows:

	Health Depts.	Boards of Education	P.H.N. Ass'ns
Beginning salary	$120.00 mo.	$1270 yr.	$110.00 mo.
Maximum salary	$140.00 mo.	$1820 yr.	$135.00 mo.
Number of years of service to receive maximum salary	3 yrs.	5 yrs.	2 yrs.

REPORT OF THE INDUSTRIAL NURSES MEETING

State Organization for Public Health Nursing, Saratoga, New York, June, 1929

Twenty-six industrial nurses were present at the meeting at which Miss Grace M. Heidel, Supervisory Nurse, New York Central Lines, presided.

Mr. W. C. Freeman, District Claim Agent, New York Central Lines, spoke on "Industrial Nursing from a Layman's Point of View." Any industrial nurse who heard Mr. Freeman's argument for greater vision in nurses in promoting the health and welfare of the worker would accept his challenge as a spur to greater effort. The layman is catching up with the average nurse in knowledge of the workers' needs and is demanding more and more of the nurse in the field of health education. He particularly emphasized the strategic place the nurse holds as a link between labor and production. She advises and coöperates in the maintenance of physical fitness of the employees, a fitness that is immediately reflected in production. He also urged the industrial nurse to recognize the value of detail in records, of understanding the industrial compensation laws, of proper dress and appearance, of active share in the safety program, and of so fine an execution of her job that industry could not fail to want to purchase it.

The discussion which followed showed that those present were eager for more professional help. In closing Miss Heidel said:

"Before entering the industrial field a nurse should be sure she is Public Health minded. To be Public Health minded is exactly what the term implies—a sincere interest in the health and welfare of the public. The public of the nurse in an industry is the personnel connected with it. Further if she *is* Public Health minded, additional training, reading of current magazines and available books, membership in her own and the State Organizations, will be an inspiration to her rather than a burden."

1930 CALENDAR OF THE LEAGUE

The National League of Nursing Education still has a supply of the 1930 calendar—nursing methods, old and new—for sale at the usual price of $1.00—$.75 for lots of 50 or more. They make attractive Christmas gifts. Orders should be sent to the League, 370 Seventh Avenue, New York City.

TUBERCULOSIS CHRISTMAS SEAL SALE

The annual Christmas Seal Sale starts after Thanksgiving. On the success of the sale depend adequate care of tuberculosis patients, prevention of infection, and the educational program of many public health nurses. Will you do your share in supporting this work?

BOARD AND COMMITTEE MEMBERS' FORUM

Edited by VIRGINIA BLAKE MILLER

Board Member, Instructive Visiting Nurse Society, Washington, D. C.

PERSONNEL IN BOARDS OF DIRECTORS OF PUBLIC HEALTH NURSING ORGANIZATIONS

BY ELEANOR CUTLER DAGGETT

Vice-President, New Haven Visiting Nurse Association

The great public health movement has been most fortunate in its pioneers. If, as Carlyle said, history is the story of great men, surely the history of public health work in the United States is the story of the constructive minds of those whose names are synonymous with its progress, and also of the devoted, faithful work done patiently and freely by less brilliant minds—the Unknown Soldiers of this campaign—whose contribution has been no less essential. To all these pioneers we owe the great opportunity we have today for further development and sound progress. Our present conditions are not the result of any haphazard process; it is not by chance that many organizations are now flourishing, responsible for the expenditure of many thousands of dollars and the welfare of many communities; the composition of many individuals into efficient administrative bodies has involved much study, much caution, much consideration.

Now we must look into the future and see how to preserve what has been gained, how progress may continue and be more effective, and how our capital of achievement may be wisely invested for further gains. The opportunity and the responsibility it brings are as mandatory upon boards of directors as on professional workers, and the future fulfillment of this great trust depends largely on the personnel of the directorates.

We must consider at this point the line of demarcation between the executive and the administrative branches of our undertaking. Broadly speaking, the administrative boards are composed of volunteers with non-standardized training, while the executives are paid and professionally trained, with requirements more or less standardized. As the facilities for training increase, requirements for the professional worker rise. Have the standards for boards of directors risen commensurately? Is the same degree of improvement to be found in the administrative department as in the executive? Are the directors as well fitted for their work as the paid workers for theirs? Have the directors who have served ten or twenty years grown as much as the senior executives? Are our boards stronger than they were ten or twenty years ago?

On the answer to these questions depends the future success of our work for no work rises higher than its source. As social work is organized at present, substantial authority is vested in the boards, and the time does not seem ripe for changing this system while a large percentage of our work is supported by more or less voluntary contributions. Directors are permanent residents of the community served; paid workers may come and go. The system is like a limited monarchy, a feature that stands. If the expense is taken over to the tax lists, the situation will be somewhat different, but we shall probably always need citizens' committees to make recommendations and ratify procedure. There must, however, be closest coöp-

eration between the two groups if we are to achieve our great object. To secure this coöperation we must make sure that there can be deep mutual respect between the lay and the professional workers. No directors are worthy of their positions unless they can command the respect and the confidence of the staff, unless they have something valuable, something vital to contribute to the paid workers. The nurses themselves have done much in board education, but the process should be mutual.

THE SCIENCE OF PERSONNEL

This leads inevitably to the conclusion that we must study the science of personnel in our boards just as carefully as in our paid staffs. There we constantly try to eliminate the cost of "hiring and firing," but though the loss of getting poor members on our boards cannot be estimated in dollars, it is serious, and, except by a sound system of rotation, is not offset by the advantage of being able to "fire" them. The selection of the first board is perhaps easier than the constant problem of keeping up its personnel. The choice of board members is not a static problem but requires special consideration for each stage of its history, although there are certain constant factors to observe.

A committee of the National Organization for Public Health Nursing will publish early in the new year a Manual for Board and Committee Members which will be of great assistance in our problems. This committee is proceeding on the sound theory that "any board is only the sum of its members and should therefore be representative of the community, no group being allowed to predominate"; also that "no board is an isolated group working alone for better health, but an important link in the great chain of the public health movement, and the strength of the whole is its strength." After several years of observation of the functioning of directors, the problem of the make-up of a board comes to me thus:

Every board must win and hold the confidence and support of the community it serves; it must hold that support so steadily that it will educate the community and lead it into an ever-broadening program adaptable to changing needs.

The individuals must recognize the fiduciary nature of their office; they must represent a variety of gifts, ages, types, and social and religious affiliations.

All members should possess good judgment and common sense, should be open-minded and teachable, coöperative, and well-informed of the needs and resources of the community. A certain proportion of them should be preëminently thinkers.

In filling vacancies choices should be made with careful study of the board as a whole to supply specific needs.

Let up take up some of the points of this creed in detail. *First*, a new organization has to win confidence through the standing of its directors. The next step is to secure money, and many organizations have to depend at first on the generosity of a few wealthy directors, but they must be chosen for their sense as well as their dollars in order to draw money from others. If we have too many wealthy directors, however, there may be a mistaken feeling that these people could finance the whole budget, and we do not secure the many steady annual small contributions on which depends the permanence of the enterprise. If the organization becomes a member of a community chest, the selection can be based solely on personal qualifications.

VARIANTS

Secondly, it requires careful study to secure suitable representation of the different social groups, professional, industrial, mercantile, and of the great religious sects, Roman Catholic, Jewish, Protestant. Demands of social work are so varied that we need also many types of personality: the conservative and progressive, the sanguine and cautious, the intuitive and plodding, the visionary and practical. We need some service requiring youth and vigor, we need a group with sound financial ability, we need other members able to supervise purchases, supplies and other physical property, others with a good publicity sense.

The advertising men say that to conduct an enterprise without publicity is like winking at a pretty girl in the dark; you may know what you are doing, but no one else does. We need still others who can stimulate the assistance of other agencies, keep contacts pleasant and friendly, guide committees with clear, incisive reasoning, inspire and cheer the staff, foresee and avoid crises, foresee and prepare for lines of advancement.

This varied service requires also a wide range of age. I do not mean chronological age, but mental age. We are all learning this distinction, and it applies closely to the administrative officers in public health nursing. We need people who are "now-minded": women and men whose mental clocks have not stopped and are not likely to run down for some time to come, whose opinions are not dated from the unfortunate moment when their clocks ran down. This is a question of the type of mind, of the mental attitude toward problems, of the "intelligence required to make progressive adjustments," as E. C. Lindeman says, of keeping the creative spark alive and the creative spirit present in all deliberations. Thus we can attract to our boards the people we most need, for the idealism inherent in the human spirit needs a vent, and if we can present rightly the opportunity this service offers, we can command and secure intelligent assistance.

Let us think further of the individual directors and their personality. Beside the qualities mentioned above—that they should be open-minded, cooperative, well grounded in their knowledge of needs and impersonal in their judgments—we need also people who really love the group they serve, be it village, city, state, or nation; not the transients, not the faddists, but the men and women whose ambition for the work is the keener because they love their community; who by the application of scientific method will not altogether eliminate sentiment. Their insight will be truer, their work more effective because to efficiency will be added the fruit of the deep instinct of the Anglo-Saxon—the love of home in its broadest sense. We need board members with concrete, definite aims for their communities, who know what is needed and how to get it.

BOTH MEN AND WOMEN

Organizations realize more and more the need of both men and women as directors. This is inevitable with the new economic position of women. Each year the leisure class of able women is smaller as more of them enter the business and professional field. The result is that a relatively small number of women at present are carrying responsibility in too many enterprises. Interlocking directorates are considered inadvisable in the business world; they are no less so in social service, for with our interests as with our human affections, there is always one who comes first, and on our boards we need directors with whom public health comes first and is the prime interest. We can make contacts with other boards by liaison committees or advisory boards, or whatever fits the need, groups that meet for definite aims, that need not be standing committees.

We might well use advisory committees more than we do; able, busy people can be secured to serve conscientiously in this capacity in matters in which their opinion is valuable. We have a right to ask what is the value of a given opinion, for the day of the dilettante is past. This all leads to the conviction that public health education must be carried on first, last, and all the time within the board and through it to the community. We talk of staff education and community education; we ought to talk and do more about board education.

THE RECRUITING PROBLEM

How shall we recruit new personnel? Each nominating committee must study this problem thoroughly. Beside the suggestions above one way is to acquire a few men who are gradually retiring from business or professional life, who will be willing to study our

problems and give their trained attention to this work. Ever since Mr. Bok's writings urging men to withdraw from the arena of active business while in sufficient vigor to devote their energies to their communities, more men are doing so, and they are of course prizes for any committees to which they may lend themselves. I believe the best work of the future will be done by boards composed of both men and women, if rightly chosen: we shall gain diversity of outlook while preserving unity of aim. There is still another source from which to draw new material: among our successful business and professional women who have perhaps married and retired for a time at least from their "jobs." If we can catch them while they still labor under the delusion that they are not going to be busy enough, we can secure fine material; these women are alert, able to master details, they are progressive, constructive. Let us take advantage of their experience, and also be constantly on the look-out for other helpful people. Let us hope profoundly that as time goes on, the opportunity for service will continue to draw men and women of finest caliber, of trained minds and formed characters, well-rounded, flexible, and sound. Is not this the basis for preserving the heritage our pioneers are handing on to us and our successors?

It is a great pleasure to be able to send a word of greeting to the many board members of the N.O.P.H.N. in their own department of the PUBLIC HEALTH NURSE magazine. I consider it an inestimable privilege to be the first Secretary for the Board and Committee Members Section, and wish you to know that I have started to work and stand ready to assist you in any way possible.

My first month or so will be spent visiting, observing, and attending local and state meetings. I have already visited Boston where I heard about the plans for a social hygiene nurse to be added to the staff and a new reorganization of the Board. I attended the first fall meeting of the Brockton Visiting Nurse Association where the work of their preschool clinic was presented. In New Haven I heard about the plans for the mental hygiene program under their new mental hygiene nurse to be added to the staff in January.

York, Pennsylvania, is to have the State Nurses Convention there this month, and they are holding a short Institute for Board Members at which Miss Tucker and Mrs. Whitman Cross are to speak.

Word has come that there is to be an Institute for Lay Members in Davenport, Iowa, at the State Nurses Meeting, and at the Indiana State Nurses Association meeting a paper is to be given on "The Rôle of Volunteers in the Public Health Nursing Program." These institutes will be reported on in later issues.

The Board Members Manual will be ready for sale early in the new year, and it will prove invaluable to you. The program at the Biennial is under way with some interesting meetings for our group alone planned, but better still, stimulating meetings where the program is to be presented both from the professional and lay point of view.

The Board Members Section has great plans for the coming year, and we hope that each of you will make suggestions and send us material for use in the Forum of interesting projects you are carrying on in your association. I am looking forward very much to working with you during the coming year.

Evelyn K. Davis

Communications for this department should be sent to Mrs. G. Brown Miller, care of THE PUBLIC HEALTH NURSE, *370 Seventh Avenue, New York City.*

POLICIES AND PROBLEMS OF PUBLIC HEALTH NURSING

HANDWASHING DRILL

Making hand washing drill a part of the school routine preceding the noon lunch will be a valuable aid in establishing this habit.

Methods for such a drill have been worked out in numerous schools with widely varying equipment. The entire time for this drill in a room of thirty pupils should not exceed five minutes:

Outdoor Drill. Where no running water is installed, hand washing should be done out of doors if the weather permits. Equipment—two large pitchers, which may be gallon pails with one side bent to form a spout; liquid soap container, possibly an old perfume or hair tonic bottle; liquid soap; paper towels, one for each child; flat toothpicks; two large buckets for waste water when washing is done indoors; and a waste basket for used towels and toothpicks. The teacher should serve as soap monitor, with two pupils as water monitors.

The children form in two lines facing each other. While the children form cup shape with their hands, the water monitor passes down one line and up the other, spilling a little water over each child's hands. The children rub the water over the hands so the entire surface is wet. Then they cup hands again, ready for the soap monitor, who passes along shaking soap into each child's hands. The child now lathers his hands well, and takes a toothpick to clean his nails. He is then ready for the second water monitor to pour on the rinsing water. After rinsing he passes to the house for a paper towel, and after drying the hands thoroughly he puts the used towel and toothpick into the waste basket.

Indoor Method. For an indoor drill, the waste buckets are placed on a bench or on stools about six feet apart. A water monitor stands behind each stool. The soap monitor stands between the buckets, nearer to the first bucket. The children form in line, and as each child comes to the first bucket he cups his hands, receiving the water over the bucket so as not to spill any on the floor. He rubs his hands and wrists to wet them all over, and passes on for the soap. Then he lathers his hands as in the outdoor drill, cleans his nails with a toothpick, stops by the second bucket for the rinsing, dries his hands and deposits towel in the waste basket.

Running water simplifies the whole process, of course. In schools so equipped the child forms a cup with his hands and allows the water to run over the hands and wrists. If powder or liquid soap is used, he should hold his hands in the same shape; if cake soap, it should be rubbed between the hands. After lathering well he cleans his nails with a toothpick or individual orange stick. He rinses by allowing the water to run over his hands and wrists while continuing the motions of lathering and rubbing.* After drying them with a towel he should rinse the bowl with clean water and wipe it dry with his used towel, which he then deposits in the waste towel basket.

* *Editor's Note*—Rinse cake of soap as well as hands.

A GAME IN HEALTH EDUCATION

From the Public Health Federation in Cincinnati comes this educational game in food values and nutrition lessons:

In the draft of a course in health and physical education, Dr. Clifford Brownell suggests a method of teaching food values which lends itself to several adaptations. The names of foods are printed upon cards with the number of miles each card entitles the pupil to move. Cards are drawn in turn and the child reaching a given destination is the winner.

The game can be made much more effective if pictures of foods cut from magazines are pasted on the cards. Many lessons may be taught by evaluating the food. A bottle of milk may count +10, a cup of coffee —10. Candy marked "before meals" may count —8,

"after meals" +3. Pickles may count —4 and fresh fruit +6. Dry cereal may count +1, with fruit +3, and cooked whole grain cereal +8. The goal may be set at 20 or 30, the score kept on the blackboard or paper, or as an oral lesson. Fractions may be used for drill. The child whose score has nearly reached the goal and is set back 10 by drawing a cup of coffee will no doubt be impressed.

EGGS—FRESH AND STALE

The following simple method of testing the age of an egg was published recently in the "Lancet," one of the great English medical papers:

A simple test to determine the age of an egg is to drop it gently into 5 or 6 inches of water in a flat-bottomed vessel containing two tablespoonsful of salt to every pint of water used. A new-laid egg will fall to the bottom and lie flat on its side. An egg between 12 and 21 days old will settle at an angle, the broad end rising. As age progresses the angle increases, until the egg stands upright on its base. Later still, it will float upright, while the rotten egg will float on its side on the surface.

This test will not work with eggs preserved in lime or waterglass, but there are three useful tests to detect preserved eggs. First, the shell will crack from crown to base in boiling. Secondly, the yolk is displaced, often touching the shell. Thirdly, the white is watery and has lost its firmness and elasticity.

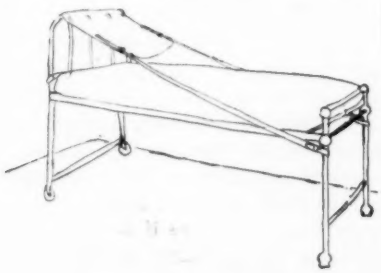
DEVICE FOR FINDING EXPECTANT MOTHERS

The Atcawana Unit of the Home Bureau has undertaken to supply to every expectant mother in the village of Attica, Wyoming County, N. Y., a home-made toilet tray for the baby *provided the mother will apply for the outfit.* The trays are made from round cake tins, and the jars are discarded mayonnaise, jelly and cold cream jars. The safety-pin cushion is a piece of white soap. The trays are enameled in blue, and each jar cover, after being enameled, is decorated with a wreath of flowers. With every tray is given a copy of the New York State booklets, "Suggestions for Prospective Mothers" and "The Baby Book." The committee of five in charge of the work includes "a real artist," who decorates the trays.

As a stimulus to interest in the health of mothers and babies, and as a means of finding the expectant mothers the plan has been very fruitful. To date forty trays have been presented to residents of Attica. About fifteen have been sold to people outside the village, even as far distant as Texas and California. The proceeds from the sales are used for Unit activities. The price of the tray is $1, plus express charges. The Unit was so greatly impressed with the difficulty in finding the mothers who most need instruction that its members developed this method of discovering them.—*New York Sun*, June 19, 1929.

CANVAS BACK REST

An entirely satisfactory bed-rest consists of a canvas back-rest which is attached to the top of the bedstead by short straps and to the end by long ones (see illustration). It offers a restful position, adjustable without disturbance, and does not cause pressure on the patient's back or cut the sheets. The straps are of English bridle leather, with non-rusting, nickel-plated buckles; the appliance is easily washed and most durable.—*The Nursing Times*, May 11, 1929.



REVIEWS AND BOOK NOTES

Edited by DOROTHY DEMING

THE ART OF THINKING

By Ernest Dimnet

Simon & Schuster, N. Y., 1928. Price $2.50.

If you have ever been embarrassed by the offer of a "penny for your thoughts," embarrassed not by the smallness of the purchase price, but by the appalling prospect of revealing the vaporings of your mind, then Dimnet has written a book that you will read with keen interest and remember to your own profit.

The Art of Thinking is delightfully easy reading, and more—it is a human approach to our common problem of living a mental life that shall ultimately enable us to attain our possibilities. We have all longed for better functioning minds, for fuller lives; Dimnet offers a practical and not unattainable program for reaching that end. The remarkable part is that the program itself is as alluring as its objective. We are invited not to drastic drills, but to an understanding of how to enjoy the use of our own minds.

Dimnet is not writing for potential genius, nor for subnormal mentalities. His is a book for average minds and he keeps the level of achievement within the grasp of every one of us. It is not by chance that he cites the roadside mechanic as one type of creative thinker and then leads through the easy gradations of the business man, physician, writer, to men of positive genius.

The stimulus to right living as well as to right thinking runs through the entire book, but becomes outspoken in the last few chapters. That you may know that he is not unaware of the distractions modern life holds for the thinker, Dimnet touches humorously on the problem of securing the needed minimum of solitude in our increasingly gregarious society, on the difficulty of concentrating the mind upon which so many stimuli constantly impinge. But self pity is not permitted! "Attention," he tells us, "is less a gift than a habit." The plea that "there is no time" is brushed aside by the stark truth of the time we waste, all of us, every day. Even the press of multiplying daily duties is convertible into material for thinking, into a medium for personal growth. That we may live our lives on a thought producing plane is convincingly demonstrated and practical help is given to that end.

The last section of his book, devoted frankly to creative thought, is prefaced by the introductory statement that "if creative thought means genius, genius is a state of mind which the humblest artisan as well as the superman may attain." It is hard to follow him here, so accustomed are we to associate genius with great gifts. Yet we understand what he means. He is inviting us to a joint aristocracy of intellect and character. He would have us admit the obligation that attaches to us at birth to live among men and recognize our privilege of choosing whether we shall do this with weakness and indifference, with strength and beauty. He attaches only one condition—that we shall be honest, that we shall find and be ourselves, "since real thought and right living cannot co-exist with anything that is not our self at its highest and noblest possibility."

If we read this book, we shall understand why French writers are so universally credited with humor and rare lucidity; we shall understand the virility of a people who are so stimulatingly challenged to personal attainment. As we close the book, we shall realize that the hazy spots of our personal philosophy have been cleared; that, with hope and courage, we have resolved afresh to achieve right living.

MARY PAGAUD

AN INTRODUCTION TO EFFICIENT STUDY HABITS

By Maude Blanche Muse, R.N., A.M.
W. B. Saunders Company, Philadelphia, Pa.
Price $1.00.

This brief, but essentially practical book, is intended to assist those mature students who feel the need for better study methods. Too often the desire for information and the knowledge of how to acquire it efficiently do not go hand in hand. In a generation when adult education is increasingly stressed and to a professional group conscious of its need, this book comes as a distinct boon. If efficient study habits were not acquired in earlier school years the return to the class room, undertaken so eagerly by many adults, bids fair to be beset with real difficulties. Time is brief, the ground to be covered great.

The author has laid down in a direct manner the fundamental laws of learning and has clearly demonstrated the value of their use as an aid in acquiring knowledge. Characterizing study as an effort on the part of the student to achieve a goal or to solve a problem, she proceeds to discuss, not only the laws which aid in economical learning, but also those sub-laws of exercise which are so important in fixing newly acquired knowledge. On this basis is built the discussion of such practical study technique as the class hour as a learning period, note taking, reading rates as an aid to study, and the essential value of examinations.

One chapter deals with concrete suggestions on how to use the library and discusses the effect of environment or physical condition upon the will to study. The summary of well tested study rules set forth in the appendix will serve as an excellent review of the more detailed exposition in the book.

Perhaps this book's greatest contribution is its emphasis on a new attitude toward study. When lessons cease to be learned "to pass an examination" and become problems to be solved in answer to a conscious desire for better methods of meeting life situations, study is no longer an artificial, forced procedure, but a vigorous attacking of new material which terminates satisfactorily in the permanent acquisition of useful knowledge.

RUTH W. HUBBARD

"Health Supervision In Industry," a new health practices pamphlet revised by Dr. C. O. Sappington, Director of the Division of Industrial Health of the National Safety Council, and reviewed by Dr. Thomas R. Crowder, the Pullman Company, Chicago, by Dr. Volney S. Cheney, Armour and Company, Chicago, and by Dr. Harry E. Mock, Chicago, has just been published. Industrial nurses will find this presentation of duties very suggestive. We quote from the paragraph on qualifications of the nurse:

> Industrial nursing must often be accomplished happily in surroundings not ideal. In the small plant, a person with initiative is needed to carry on health service work and a person with ability is very often required because of the very nature of conditions.
>
> In addition to a liberal education, the usual hospital training, and experience in public health nursing, it is often desirable for the nurse to have a knowledge of many other subjects allied to the practice of medicine in order to be of incidental service to the employees of the plant. The ability to advise on well-balanced meals, suitable menus for lunchrooms, significant points regarding housekeeping, clothing, etc., will enhance the value of the health service department and will make that department more popular with employees. Familiarity with the language of the workers will very often save a difficult situation.
>
> The work is very strenuous, and requires a healthy, vigorous body, with an adaptable disposition and an understanding mind. Likewise familiarity with industrial disease, especially disease incident to the particular industry in which she is employed, and ready familiarity with all legal provisions and public agencies related to sickness will very often be a great help to the health service department.

For copies of this pamphlet write to the National Safety Council, 108 East Ohio Street, Chicago, Illinois.

Writing about health for the layman "in simple terms" has become quite the fashion, and we are glad to add another textbook on health to the growing list—*What Everyone Ought to Know* by Oliver T. Osborne, M.D. (Charles C. Thomas, publisher, Springfield, Ill., price $2.50.) This book will be of greater interest to the nurse's patients than to the nurse to whom much of the material is or should be familiar.

Findings and conclusions from a study of 6,000 cases of sterilizations in California are presented in a recent volume, "Sterilization for Human Betterment," by E. S. Gosney and Paul Popenoe. (The Macmillan Company, New York City. $2.00.)

The American Nurses Association has prepared an Historical Sketch of the Association which every nurse will want to own. It "tries only to emphasize the outstanding events in the development of the organization and to place the official association of nurses in its relation to the growth of the profession in the United States and to other nurse groups." Copies of the sketch may be obtained from headquarters, 370 Seventh Avenue, New York City.

The National Tuberculosis Association, 370 Seventh Avenue, New York City, has issued a helpful leaflet called "Posters for Health Teaching," which will be useful for school nurses and teachers. Copies may also be secured from the State Tuberculosis Associations.

The Visiting Nurse Association of New Haven, Conn., has issued a new nursing manual approved by the Medical Advisory Committee—price 50¢.

Preparing the Nurse for Service in the Public Health Field—an article by Miss Katharine Tucker appeared in *The Modern Hospital* for August 1, 1929.

From a reading list used in the Boston Community Health Association we take the liberty of quoting these books on mental problems of children:

Blanton—Child Guidance.
Cameron—The Nervous Child.
Cleveland—Training the Toddler.
De Schweinitz—Growing Up.
Gesell—Mental Growth of the Pre-School Child.
Groves—Wholesome Childhood.
Hollingworth—The Psychology of the Adolescent.
O'Shea—The Child, His Nature and His Needs.
Thom—Everyday Problems of the Everyday Child.

Novels

Bjorkman—The Soul of the Child.
Butler, S.—The Way of All Flesh.
Deeping, W.—Old Pybus.
De Selincourt—One Little Boy.
Ferber—So Big.
Gilbreth—Living with Our Children.
Kipling—Storky and Co.
Parrish, A.—All Kneeling.
Wells, H. G.—Bealby.

Parents and the Preschool Child by William B. Blatz and Helen Bott (William Morrow & Co., New York, $3.00), differs from several books on the subject in that it is based entirely on first-hand studies of normal children. Not the problem child, but problems of the normal child, engage the author's attention.

The first of the three sections into which the book is divided deals with topics fundamental for parents, such as the behavior of young children and habit formation, with a topical outline, selection of illustrations, and a case study appended to each chapter.

Part II is intended for professional workers and leaders in parent-education groups. It briefly sketches the history of the mental hygiene movement and shows the relation between that and problems of child rearing.

Part III contains charts, forms, and records such as are used in the clinical consultation service of the St. George's School, and are recommended for the use of parents in observing their children.—*Child Welfare Magazine.*

NEWS NOTES

The White House Conference on Child Health and Protection, of which Dr. Ray Lyman Wilbur is Chairman, has been called by President Hoover. The first Conference called by President Roosevelt twenty years ago was devoted chiefly to the problem of the dependent child. The second conference was organized by the Children's Bureau in 1919, at the suggestion of President Wilson. The data obtained in the appraisal of six million children taken during the last year of the war, were the basis of the studies for the 1919 Conference.

In the ten years since the last Conference it is believed children have made definite progress in mental and physical health. It is the President's thought that it is now time to check up what we believe against facts.

Some twenty committees will be organized for work in the fields which relate to the health, education, and protection of the child. Four major groupings of the problems have been tentatively made: Growth and Development, Medical Service, and Public Health Administration, Education and Training, and the Handicapped Child.

The President has summarized the purpose of the Conference in this definite way:

"We already have enough knowledge which, if brought together, compared, and sorted, would give us some approach to the normal child. The crux of the problem is, as quickly as possible to bring what knowledge we have into the open, broadcast it, and make it familiar to the average busy, but deeply concerned, parent."

The Wisconsin Legislature has appropriated $51,000.00 for the Bureau of Child Welfare and Public Health Nursing with the proviso that in the event that federal legislation is enacted which will grant federal aid to states for child welfare work, the department will reimburse to the general fund dollar for dollar the sum obtained from the federal government.

The Legislature also granted an increase in the appropriation for health work among the Indians, this year, $15,000.00.

Much of the program at the National Conference on Social Work in San Francisco dealt with problems peculiar to the workers specializing in the mental hygiene field and revealed material that will concern these specialists in a way and a degree, perhaps, that delineate a sector that must for some time to come be somewhat "off the beat" of the general social case worker. The speakers discussed such subjects as team work in the clinical unit, the special techniques of the mental-health case worker, the importance of treating the parent in juvenile behavior cases, and of the case worker understanding her own attitudes, the visiting teacher as psychiatric social worker, the development of state societies for mental hygiene, and the further extension of mental-health work into courts and correctional institutions. Various child-guidance and other mental-hygiene clinics and institutions, and state and local mental-health organizations, as well as The National Committee for Mental Hygiene, were represented on the program.

During the week of October 21 the Henry Street Visiting Nurse Service carried on a Visiting Nurse Service Week, as a means of educational publicity. No appeal for funds was made at this time, the effort being purely to show the people of New York what resources are available at little or no cost in time of illness.

It is a pleasure to announce that Miss Mildred C. Smith's article "Reminders to School Nurses—Conserving Sight and Vision Testing," which appeared in the September and October numbers of THE PUBLIC HEALTH NURSE, is available in reprint form. Orders should be sent to the National Society for the Prevention of Blindness, 370 Seventh Avenue, New York City.

Mrs. Helen W. Munson, R.N., B.S., formerly instructor in a course in Comparative Nursing Methods at Teachers College, has joined the staff of the *American Journal of Nursing* as assistant to the editor.

Philip S. Platt, Ph.D., has accepted the position of Director of the Palama Settlement, Honolulu, having resigned as Executive Secretary of the Associated Out-Patient Clinics Committee and Assistant Director of the New York Tuberculosis and Health Association.

The Visiting Nurse Service of Milwaukee, Wis., has announced the adoption of a group insurance program providing life insurance and sick and accident benefits for employees of the Service. The contract is being underwritten by the Metropolitan Life Insurance Company.

The next Wisconsin State Board Examination for the registration of nurses will be held on December 3, 4, 5, and 6, 1929, in the City Hall, Milwaukee, and the Court House, Ashland. Application blanks must be on file at the State Board of Health office ten days before the examination.

Mme. Curie has arrived in the United States to accept the second gram of radium presented to her by her American friends. It will be recalled that some years ago Mme. Curie came to this country and was presented at that time with a gram of radium, costing $110,000.00. This Mme. Curie presented to the Curie Institute at the University of Paris. The present gram costs only $50,000.00, due to Mme. Curie's own work in reducing labor costs in obtaining the metal. She also devoted the income from the fund given to her for her use to the cancer hospital of Warsaw, her native city.

The Community Health Association of Boston has appointed a social hygiene worker on their staff—Mrs. Evangeline Morris, a graduate of Bishops College, Quebec, and the Yale School of Nursing. Mrs. Morris has had experience as Staff Nurse and Assistant Health Supervisor on the Community Health Association staff. Before beginning her new work, she is taking two months to prepare herself. An advisory committee, composed of medical specialists and medical social workers in the field, has been appointed to help her in her new job.

Miss Elma Rood, who has been connected with the Department of Nursing Education at George Peabody College for Teachers, in the capacity of Associate Professor of Nursing Education, has been appointed Director of the Peabody-Vanderbilt Course in Public Health Nursing.

APPOINTMENTS

Dorothy E. Wright has been appointed as instructor in Health Education for the new three year course in the State Normal School, Jersey City, New Jersey. Miss Wright will also demonstrate Health Service in the capacity of school nurse in the Demonstration School as well as the Normal School.

Mrs. Elizabeth Semenoff and Mrs. Elizabeth Morgan Lappin have recently been appointed to the staff of the Bronx Tuberculosis and Health Committee.

Erna R. Kuhn, R.N., has been appointed to the staff of the Department of Health Service of Cleanliness Institute, New York City.

The Joint Vocational Service reports the following placements:

Hilda George, formerly in the Indian Service, as Teacher-Nurse in the Public Schools of Tenafly, New Jersey.

APPOINTMENTS—Continued

Ellen Reather as County School Nurse for Bannock County, Idaho.

Berneta Platt, formerly with the Bellevue-Yorkville Demonstration, has joined the nursing staff of the Metropolitan Life Insurance Company, New York City.

Frances Cleave, until recently the Superintendent of the Community Hospital, Farmville, Virginia, as Director of the Detroit Health Center, Detroit, Michigan.

Hortense Hilbert, for the past several years associated with the child health work in Austria promoted by the Commonwealth Fund, as Staff Associate of the American Child Health Association, New York City.

Margaret M. Davies, formerly Supervisor of Child Welfare of the Pittsburgh Public Health Nursing Association, as Supervisor, Visiting Nurse Association, Elizabeth, N. J.

Helen Ronan as Maternity-Infancy Nurse at the Teaching Center conducted by the New York State Department of Health at Fulton, New York.

Willarette Sears, formerly Director of Nursing in the Demonstration in Mansfield, Ohio, and the past year a student at Teachers College, as Maternity-Infancy Consultant, New York State Department of Health.

Louise M. Murphy as Community Nurse, Chico, California.

Other placements that have come to the attention of Joint Vocational Service include that of:

Edna L. Hamilton as Director of Nursing, Children's Fund of Michigan, Detroit, Michigan.

Frances Brink, formerly on the staff of N.O.P.H.N., to the position of Teaching Supervisor, Bellevue Hospital, New York City.

Elizabeth Miller, recently connected with the State Department of Welfare, Harrisburg, Pennsylvania, to the position of Superintendent of Nursing, Lincoln Hospital, New York City.

Florence Little as Head Nurse of the Burrillville District Nursing Association, Harrisville, Rhode Island.

Bess Hair as Public Health Nurse, Harrison County Health Unit, Clarksburg, W. Va.

Dorothy Allen as American Red Cross Public Health Nurse, Dalton, Mass.

Frances Hersey as Assistant Superintendent of the Community Hospital, Wauseon, Ohio.